2/9/18

PRINTED: 12/14/2017
FORM APPROVED

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
	520023	A. BUILDING: _____ B. WING _____	C 11/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE - IOWA CITY	4569 JENN LANE IOWA CITY, IA 52240

(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
C 000	Initial Comments The following deficiencies were cited during the investigation of Complaint #71493-C:	C 000		
C 147	50.7(4) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility did not notify the Department of elopements as required for 1 of 1 resident reviewed who left the facility without permission (Resident #2). Findings follow: A review of incident reports and monthly progress reports revealed Resident #2 eloped from the facility on 6/19/17, 6/20/17, 7/18/17, 7/20/17, 7/21/17, 7/24/17, 7/30/17, 8/1/17 and 9/28/17. These elopements were not reported to the Department. Resident's #2's diagnoses included traumatic brain injury, vascular dementia with behavioral disturbances. During an interview with Staff P on 11/27/17 at 12:03 PM, he stated staff were now following	C 147		

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C 147	Continued From page 1 Resident #2's behavior plan. Staff P did not believe Resident #2 was safe to go on unsupervised walks due to his inability to follow safety cues During an interview with Staff O on 11/27/17 at 12:26 PM, Staff O did not think Resident #2 was safe when he eloped from the facility. Interview with Staff B and Staff C on 10/31/17 at 10:42 AM revealed they were not aware of the reporting requirements regarding elopement.	C 147		
M 201	63.8(6)b Administrator 481-63.8(135C) Administrator. Each residential care facility for the intellectually disabled shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. 63.8(6) The licensee shall: b. Be responsible for compliance with all applicable laws and with the rules of the department; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to comply with requirements related to notifications to the Department found in Iowa Administrative Code 481-chapter 50. Findings include: A review of facility records revealed the facility failed to notify the Department of elopements as required by Iowa Administrative Code rule 50.7(4). Interview with Staff B and Staff C on	M 201		

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DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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M 201	Continued From page 2 10/31/17 at 10:42 AM confirmed this finding. See deficiency under 50.7(4) for details.	M 201		
M 333	63.17(1)l Records 481--63.17(135C) Records. 63.17(1) Resident records. The licensee shall keep a permanent record on all residents admitted to a residential care facility for the intellectually disabled with all entries current, dated, and signed. The record shall include: l. Physician's orders for medication, treatment, and diet in writing and signed by the physician; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure signed physician orders were in place prior to administering treatment to 1 of 2 current residents reviewed (Resident #1). Findings follow: Resident #1 received Calmoseptine ointment for help in healing pressure ulcers. No orders for this treatment could be located in the resident's file. Calmoseptine was not listed on the Treatment Administration Record. Staff E stated during an interview on 10/25/17 at 3:47 PM that Resident #1 received Calmoseptine for treatment of pressure ulcers.	M 333		

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M 333	Continued From page 3 Interview with Staff B on 10/30/17 at 2:40 PM indicated Resident #1 had told Staff B he/she used Calmoseptine prior to admission to the facility and continued usage while at the facility.	M 333		
M 348	63.17(2)e Records 481-63.17(135C) Records. 63.17(2) Incident record. e. The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure incident reports were written regarding accidents or unusual occurrences for 2 of 2 current residents reviewed (Resident #1, #2). Findings follow: 1. When interviewed on 10/25/17 at 10:12 AM, Resident #1 and Staff M relayed incidents in which Resident #1 reported falling from a wheeled walker at home and falling when getting into a facility vehicle on a different day, both while under the care of Staff D. Interviews with Staff E on 10/25/17 at 3:47 PM and Staff G on 10/26/17 at 10:55 AM revealed they were aware of the events Resident #1 reported, but did not know if incident reports had been written to document what had occurred.	M 348		

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M 348	Continued From page 4 Interview with Staff D on 10/31/17 at 3:28 PM revealed she had asked the Administrator if an incident report needed to be completed regarding the fall Resident #1 had when getting in the facility vehicle. Staff D reported the Administrator told her an incident report was not needed. 2. A review of monthly progress reports for Resident #2 revealed the resident eloped from the facility on 7/18/17, 7/20/17, 7/21/17, 7/30/17, 8/1/17 and 9/28/17. No incident reports regarding these elopements could be located. Staff B confirmed on 10/31/17 at 10:13 AM that no incident reports could be found regarding these falls or elopements.	M 348		
M 519	63.23(3)e Safety 481-63.23(135C) Safety. The licensee of a residential care facility for the intellectually disabled shall be responsible for the provision and maintenance of a safe environment for residents and personnel. 63.23(3) Resident safety. e. Residents shall receive adequate supervision to ensure against hazards from themselves, others, or elements in the environment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	M 519		

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M 519	Continued From page 5 failed to ensure adequate supervision was provided for 2 of 2 current residents reviewed (Residents #2 and #1). Findings follow: 1. Record review revealed Resident #2 was admitted to the facility on 6/16/17 from a psychiatric unit at a hospital. Resident #2's diagnoses included traumatic brain injury and vascular dementia with behavior disturbances. A hospital report dated 5/27/17 indicated the hospitalization, prior to admission to the facility, was a result of Resident #2 being missing for several hours and being arrested for 5th degree theft. In addition, Resident #2's family member reported Resident #2 had a history of loitering and rummaging through garbage cans. The Administrator sent out a memo to staff dated 6/16/17 directing staff to watch Resident #2 closely to ensure there were no elopement attempts. Resident #2 eloped from the facility on 6/19/17 and 6/20/17. The Administrator sent another memo to staff dated 6/20/17 which instructed staff to remain with Resident #2 while he/she was outside smoking or keep visual contact on him/her when outside "at all times" due to the two elopements. Resident #2 eloped from the facility again on 7/18/17, 7/20/17, 7/21/17, 7/24/17, 7/30/17, 8/1/17 and 9/28/17. A Behavior Support Plan (BSP) was provided to staff by the Behavior Analyst on 7/25/17 with the direction to "start using it immediately". The Behavior Analyst sent a memo to staff again on 8/1/17 stating they should begin using the plan "immediately." In an interview with the Behavior Analyst on	M 519		

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M 519	Continued From page 6 11/27/17 at 12:52 PM, she reported the plan had not been implemented when she reviewed the behavior tracking sheets on 8/1/17. On 8/29/17, the Behavior Analyst sent another memo to staff regarding use of the plan and data collection sheets. She wrote, "In the last 2 weeks, out of 14 possible data collection days, 1st shift staff had only completed the aforementioned task 4 times. In the last 2 weeks, out of 14 possible data collection days, 2nd shift staff had completed this task 9 out of 14 times." During an interview with Staff J on 10/27/17 at 9:01 AM, she stated she was surprised when she arrived at the facility one morning to find the only staff person on duty asleep, especially because of Resident #2's history of elopement. During an interview with Staff O on 11/27/17 at 12:26 PM, she stated staff do not go outside with Resident #2 at this time, but they always watch him. Staff O did not think Resident #2 was safe when he eloped from the facility as Resident #2 was often found walking along a busy highway. Staff O reported a time when she was driving to the facility and found Resident #2 walking along the highway. Staff O picked up Resident #2 and returned him to the facility. Staff O found Staff M sitting in the living room. Staff O reported Staff M told her she thought Resident #2 was in his bedroom. During an interview with Staff P on 11/27/17 at 12:03 PM, he stated when Resident #2 was outside, he checked on the resident every minute. Staff P reported he believed the requirement of keeping Resident #2 in the line of sight changed when the new Behavior Support Plan was put into effect on 7/25/17. The BSP	M 519		

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M 519	Continued From page 7 made note of the memo written by the Administrator on 6/20/17 requiring Resident #2 to remain in the line of slight of staff when outside. Staff P did not believe Resident #2 was safe to go on unsupervised walks due to his inability to follow safety cues. During an interview with Staff B and the Behavior Analyst on 10/31/17 at 11:32 PM, they confirmed the facility polity was for all staff members to be awake at work. The Behavior Analyst confirmed when Resident #2 was outside of the bedroom, staff were to keep him within their line of sight at all times. The Behavior Analyst stated Resident #2 should have never been out of staff eye sight when outside smoking and that if staff had followed the Administrator's memo dated 6/20/17, that should have taken care of it (the eloping) but that staff obviously "were not taking the memo seriously." 2. During an interview with Resident #1 and Staff M on 10/25/17 at 10:12 AM, the resident reported being improperly transported by Staff D in a wheeled walker which resulted in a fall. Resident #1 reported telling Staff D repeatedly he/she was sitting on the seat of the wheeled walker backwards. When interviewed on 10/25/17 at 3:47 PM, Staff E reported hearing Resident #1 yelling at Staff D, "I told you I was on wrong." Resident #1 was lying on the floor when she arrived at the scene. No documentation regarding this incident was located. During an interview with Staff D on 10/31/17 at 3:28 PM, Staff D could not recall ever transporting Resident #1 in a wheeled walker.	M 519		

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M 519	Continued From page 8 On 10/26/17 at 10:55 AM, Staff G reported training Staff D on proper usage of the wheeled walker and that Resident #1 should not be pushed when sitting on the seat of the walker. Interview with Staff N on 10/25/17 at 12:58 PM revealed a wheeled walker was not to be used as a wheelchair. Staff N provided a facility in-service on 10/10/17 to train staff on how to properly transfer/transport individuals.	M 519		
M 739	63.39(1) Dignity preserved 63.39(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs. 63.39(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were treated with dignity and respect, specifically 1 of 2 current and 2 of 2 former residents reviewed (Residents #1, C-1, C-2). Findings follow: Interview with Resident #1 on 10/25/17 at 10:12 AM revealed a number of concerns with the treatment he/she received from Staff D. Resident #1 reported an incident in which he/she was	M 739		

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M 739	Continued From page 9 being transported on a wheeled walker. Resident #1 said he/she was asked to sit on it backward by Staff D. Resident #1 stated he/she told Staff D he/she thought he/she would fall from the wheeled walker and this did occur. Resident #1 also reported an incident while at a medical appointment regarding concerns with dizziness. Resident #1 was being transferred from a wheelchair to the car. The resident reported when standing up from the wheelchair to get in the car he/she felt dizzy. Resident #1 believed Staff D allowed him/her to fall. Resident #1 stated on a different date Staff D took him/her to the bathroom, stood him/her up over the toilet and asked him/her to sit down. Resident #1 stated he/she was not over the toilet seat and fell, hitting the wall. Resident #1 also reported a history of negative verbal interactions with Staff D. Interview with Resident C-1 on 10/30/17 at 2:37 PM revealed he/she no longer lived at the facility. Resident C-1 voiced no concerns with staff treatment while at the facility, except from Staff D. Resident C-1 reported Staff D wouldn't help Resident C-2 and often ignored him/her. Resident C-1 stated Staff D would not change Resident C-2's soiled brief but waited for the next shift person to come to work, "even if it was 2 PM and staff didn't come on until 3 PM". Resident C-1 reported Staff D wouldn't give him/her treatments. Resident C-1 stated he/she needed help putting on cream due to having poor balance and having a hard time reaching his/her feet and scalp. Staff D refused to help with this, according to Resident C-1, even when all other staff did provide assistance. Resident C-1 stated he/she reported this to the Administrator. A statisfaction survey completed by Resident C-1	M 739		

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M 739	Continued From page 10 upon discharge from the facility had a comment on it which stated, "Fire [Staff D]". On 10/26/17 at 9:40 PM, Staff C reported Staff D "rubs participants the wrong way." Staff C reported seeing Staff D act in a way that was rude and unprofessional. Interview with Staff E on 10/25/17 at 3:47 PM revealed Resident #1 got along well with everyone except for Staff D. Staff E stated Resident #1 and Staff D did not get along and was aware Resident #1 blamed Staff D for falls which had occured. Staff E reported Staff D did not like to apply cream to Resident #1 or Resident C-1 which caused them to become angry. Interview with Staff F on 10/26/17 at 11:27 AM revealed she had been told by Staff D that Resident C-2 had been "hollering for help" for 20 minutes when Staff F reported to the facility one day to start her shift. Staff F reported Staff D told her Resident C-2 had a soiled brief and she could not change it because Resident C-2 was too heavy for her to lift. Staff F stated Staff D did lift Resident C-2 the following day. Staff F said she reported this conversation to the Administrator. Interview with Staff G on 10/26/17 at 10:55 AM revealed Staff D told her that she (D) didn't like Resident #1. Staff G believed Staff D did things to instigate situations with Resident #1 rather than walk away. Staff G said Staff D would "challenge" Resident #1. She stated Staff D did not like to put cream on Resident #1's pressure ulcers so Staff D reportedly said Resident #1 could not have the cream. Staff G reported a	M 739		

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M 739	Continued From page 11	M 739		

time when she trained Staff D on how to put a cream on Resident C-1. Staff G stated Resident C-1 could not apply the cream to him/herself due to issues with balance and mobility. Staff D reportedly called the Administrator and said Resident C-1 could apply the cream him/herself but refused to do so. Staff G stated staff needed to apply the cream or else Resident C-1 would get sores. Staff G stated she provided training to Staff D on transfers and lifts. She stated Staff D didn't like to get close to residents and that was required in order to take care of Resident #1.

Interview with Staff H on 10/27/17 at 1:58 PM revealed Staff D could be very direct in talking with residents at the facility. Staff H overheard Staff D tell residents things such as they would be watching the movie she picked out instead of what they had chosen.

Interview with Staff I on 10/27/17 at 9:49 AM revealed residents at the home had made complaints about Staff D such as Staff D either didn't do things for them or it took her her a long time before doing it.

On 10/27/17 at 9:01 AM Staff J reported seeing an incident between Staff D and Resident #1 which she found to be inappropriate. Resident #1 was yelling racial slurs at Staff D. Staff J entered the room and asked Staff D to leave in an attempt to deescalate the situation. Staff D reportedly refused to do so and called Resident #1 prejudiced. Staff J described Staff D's behavior as controlling and unprofessional. Staff J also reported multiple occasions in which she heard Staff D and another staff (she couldn't recall who) "making fun" of residents when other residents were present.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520023	A. BUILDING: _____ B. WING _____	C 11/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 739	Continued From page 12 On 10/27/17 at 8:33 AM Staff K reported being told by Resident #1 that Staff D "doesn't take care of me" and "she doesn't like me." Staff K heard Staff D say, "Whatever [Resident #1]" once when she left Resident #1's bedroom. On 10/27/17 at 8:22 AM Staff L reported on one occasion Staff D told Resident #1 his/her cream for treatment of pressure ulcers could not be located. Staff L was unsure if the cream was ever applied. On 10/31/17 at 3:28 PM Staff D denied treating residents in a disrespectful manner. She could not recall a time when she had raised her voice to Resident #1 or any other resident. She denied talking about residents. Staff D stated she applied cream to Resident #1 whenever he/she asked for the cream. Regarding Resident C-1 Staff D felt he/she could apply the cream independently so she did not apply the cream for him/her even though she had been trained to do so by Staff G. Staff D could not recall a time when she did not provide good care to Resident C-2 and never left him in a soiled brief. Interview with Staff A on 10/26/17 at 8:50 AM revealed she was aware the Administrator had received reports of concerns between Staff D and other staff members. On 10/30/17 at 4:30 PM the Administrator was aware there were problems between Resident #1 and Staff D. The Administrator stated two workers were usually present on each shift and the second staff person should have been the lead staff for Resident #1 instead of Staff D. The Administrator was not aware of Resident #1's	M 739		

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M 739	Continued From page 13 concerns about falls being caused by Staff D. The Administrator stated he had not received reports from other staff members about Staff D's interaction with residents or the cares she provided.	M 739		
M 807	63.47(13)a Specialized License for 3-5 bed facilities 63.47(13) "Individual program plan" shall be a written plan for the provision of services to the person and, when appropriate, to the person's family, that is developed and implemented, using an interdisciplinary process, which identifies the person's and, when appropriate, the person's family's functional status, strengths, and needs, and service activities designed to enable a person to maintain or move toward independent functioning. The plan is developed in accordance with the developmental model, which is a service approach that recognizes and assumes the potential for positive change, growth, and sequential development in all people. (II) a. An individual program plan shall be developed and implemented for each individual accepted for service, regardless of the individual ' s chronological age or developmental level. (I, II) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff followed the individual program plan for 1 of 2 residents reviewed (Resident #2). Findings follow: Record review revealed Resident #2 was	M 807		

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M 807	Continued From page 14 admitted to the facility on 6/16/17 from a psychiatric unit at a hospital. Resident #2's diagnoses included traumatic brain injury and vascular dementia with behavior disturbances. A hospital report dated 5/27/17 indicated the hospitalization, prior to admission to the facility, was a result of Resident #2 being missing for several hours and being arrested for 5th degree theft. The Administrator sent out a memo to staff dated 6/16/17 directing staff to watch Resident #2 closely to ensure there were no elopement attempts. Resident #2 eloped from the facility on 6/19/17 and 6/20/17. The Administrator sent another memo to staff dated 6/20/17 which instructed staff to remain with Resident #2 while he/she was outside smoking or keep visual contact on him/her when outside "at all times" due to the two elopements. Resident #2 eloped from the facility again on 7/18/17, 7/20/17, 7/21/17, 7/24/17, 7/30/17, 8/1/17 and 9/28/17. A Behavior Support Plan (BSP) was provided to staff by the Behavior Analyst on 7/25/17 with the direction to "start using it immediately". The BSP included a step for staff to offer the resident a brief daily trip to the gas station. The Behavior Analyst sent a memo to staff again on 8/1/17 stating they should begin using the plan "immediately." In an interview with the Behavior Analyst on 11/27/17 at 12:52 PM, she reported the plan had not been implemented when she reviewed the behavior tracking sheets on 8/1/17. On 8/29/17, the Behavior Analyst sent another memo to staff regarding use of the plan and data collection	M 807		

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M 807	Continued From page 15	M 807		

sheets. She wrote, "In the last 2 weeks, out of 14 possible data collection days, 1st shift staff had only completed the aforementioned task 4 times. In the last 2 weeks, out of 14 possible data collection days, 2nd shift staff had completed this task 9 out of 14 times."

During an interview with Staff O on 11/27/17 at 12:26 PM, she stated staff do not go outside with Resident #2 at this time, but they always watch him. Staff O reported a time when she was driving to the facility and found Resident #2 walking along the highway. Staff O picked up Resident #2 and returned him to the facility. Staff O found Staff M sitting in the living room. Staff O reported Staff M told her she thought Resident #2 was in his bedroom.

During an interview with Staff P on 11/27/17 at 12:03 PM, he stated staff were now following Resident #2's behavior plan. He also stated when Resident #2 was outside, he checked on the resident every minute. Staff P reported he believed the requirement of keeping Resident #2 in the line of sight changed when the new Behavior Support Plan was put into effect on 7/25/17. The BSP made note of the memo written by the Administrator on 6/20/17 requiring Resident #2 to remain in the line of slight of staff when outside.

During an interview with Staff B and the Behavior Analyst on 10/31/17 at 11:32 PM, the Behavior Analyst confirmed when Resident #2 was outside of the bedroom, staff were to keep him within their line of sight at all times. The Behavior Analyst stated Resident #2 should have never been out of staff eye sight when outside smoking and that if staff had followed the Administrator's

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M 807	Continued From page 16 memo dated 6/20/17, that should have taken care of it (the eloping) but that staff obviously "were not taking the memo seriously."	M 807		
M 831	63.47(16)d Specialized License for 3-5 bed facilities 63.47(16) A review of the individual program plan shall be made at least quarterly by a member or members of the individual's interdisciplinary team, as determined by the team, in order to ensure the continuing implemented appropriateness of the plan and any necessary action to be initiated. d. The team review shall modify activities or objectives as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure individual program plans were modified when needs changed for 1 of 2 current residents reviewed (Resident #1). Findings follow: Resident #1 moved to the facility on 5/11/17. A review of incident reports revealed Resident #1 fell on 5/26/17, 5/30/17 (twice), 6/6/17, 6/16/17, 6/22/17 and 7/9/17. Resident #1 did not have a goal in his/her individual program plan which addressed falling.	M 831		

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M 831	Continued From page 17 An interview with Staff B and Staff C on 10/31/17 at 3:08 PM confirmed these findings.	M 831		

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2/9/18

Plan of Correction

Deficiency Cited: 50.7 (4) Additional Notification

50.7 (10A, 135C) Additional Notification, The director or the directors designee shall be notified within 24 hours, or the next business day, by the most expeditious means available.
50.7(4) When a resident elopes from a facility. For the purposes of this sub rule "elopes" means when a resident who has impaired decision-making ability leave the facility without the knowledge or authorization of staff.

Corrective Action Plan:
Going forward we will comply with code 50.7, ensuring the director or directors designee be notified within 24 hours or next business day by the most expeditious means available.

Deficiency Cited: 63.8 (6) b Administrator

63.8 (6) b The administrator will be responsible for compliance with all applicable laws and with the rules of the department.

Corrective Action Plan:
Going forward we will comply with code 63.8(6), ensuring the administrator complies with the laws and rules of the department.

Deficiency Cited: 63.17 (1) Records

63.17 (1) Resident Records. The license shall keep a permanent record on all residents admitted to the a residential care facility for the intellectually disabled with all entries current, dated and signed. The record shall include: Physician orders for medications, treatment and diet in writing and signed by the physician.

Corrective Action Plan:
Going forward we will comply with code 63.17 (1), ensuring that all residents records shall include physician orders for medications, treatments and diets in writing and signed by the physician.

Deficiency Cited: 63.17 (2) Incident Records

63.17 (2) Incident Records. The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees.

Corrective Action Plan:
Going forward we will comply with code 63.17 (2), ensuring that all incident reports are completed for any accidents or unusual occurrences within the facility or on the premises affecting residents, visitors or employees.

2/7/18

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Deficiency Cited: 63.23 (135C) Safety

63.23 e Residents shall receive adequate supervision to ensure against hazards from themselves, others, or elements in the environment.

Corrective Action Plan:
Going forward we will comply with code 63.23 e, ensuring that all residents receive adequate supervision to ensure against hazards from themselves, others or elements in the environment. The administrator will work closely with the Life Skills Trainers to ensure supervision of all clients and support plans are followed at all times when a client is known for elopement risk.

Deficiency Cited: 63.39 (1) Dignity Preserved

63.39 (1) Dignity Reserved. The resident shall be treated with consideration, respect and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs.

Corrective Action Plan:
Going forward we will comply with code 63.39 (1) ensuring each resident be treated with consideration, respectfulness, and full recognition of his/her dignity and individuality.

Deficiency Cited: 63.47 (13)a Specialized License for 3-5 bed facilities

63.47 (13) a Individual Program Plan. An individual program plan shall be developed and implemented for each individual accepted for service, regardless of the individual ' s chronological age or developmental level.

Corrective Action Plan:
Going forward we will comply with code 63.47 (13) a, ensuring an individual program plan is developed and implemented for each individual accepted for service, regardless of the individual ' s chronological age or developmental level.

Deficiency Cited: 63.47 (16) d Specialized License for 3-5 bed facilities

63.47 (16) d. The team review shall modify activities or objectives as necessary within the individual program plan.

Corrective Action Plan:
Going forward we will comply with code 63.47 (16) d, ensuring that the individual program plan is modified as often as necessary to meet the needs of the client.

These corrective action plans will be in place 2/6/18 and will be monitored by the State Director of Iowa to ensure future compliance.

Please feel free to contact me with any additional questions at 563-321-5706 or at Ashley.smith@neurorestorative.com

Sincerely,

Ashley Smith, MSM- State Director- Iowa

NeuroRestorative- Iowa