V 6/25/18

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
	330278	A. BUILDING: _____ B. WING _____	C 04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW	18569 LANE ROAD FAYETTE, IA 52142

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R 000	Initial Comments No deficiencies were cited during the investigation of Incident #75086-I or Complaint #75197-C. The following deficiencies were cited during the investigation of Incident #74935-I, Incident #75089 and Incident #75084-I.	R 000		
R 368	481-57.11(5)d Personnel 481-57.11(135C) Personnel. 57.11(5) Supervision and staffing d. Staff shall be aware of and provide supervision levels based on the present needs of the residents in the staff 's care. The facility shall document the supervision of residents who require more than general supervision, as defined by facility policy. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the policy for client safety included sufficient directives for staff to ensure adequate supervision was provided for 1 of 2 residents reviewed on increased supervision levels (Resident #13). Findings include: Resident #13 was admitted to the facility on 1/18/18 with diagnoses including schizophrenia, mild intellectual disability and a history of	R 368	P35 Safety Policy reviewed and revised by board approval on 06/14/18. -clearly states expectations for direct supervision -also retrained staff at Inservice on 05/02/18 on Crisis Development Model to help recognize client's behavior/crisis level	06/14/18 05/02/18

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Vertheen
TITLE: Administrator/CEO
(X6) DATE: 6/14/18

6/22/18

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R 368	Continued From page 1 polysubstance abuse. Resident #13's file indicated only one minor disagreement with a roommate from admission through March 2018. The resident was hospitalized on 4/9/18 and subsequently discharged from the facility. Review of Progress Notes dated 4/7/18 at 8:40 am revealed Resident #13 assaulted three peers within a short period of time. Law enforcement was notified and Resident #13 was arrested. A Progress Note dated 4/7/18 at 3:07 pm indicated Resident #13 returned to the facility with no contact orders regarding the 3 residents previously assaulted. The resident was placed on 1:1 supervision at all times until asleep for a solid hour at night. At that time 15 minute checks were to be completed until he was awake at which time 1:1 supervision would resume. A Progress Note dated 4/8/18 at 8:41 am indicated Resident #13 was sitting in a chair outside the report room with a staff standing near him. Resident #6, who had been assaulted by Resident #13 the day before, walked into the area. Resident #13 "bolted" out of the chair and struck Resident #6 in the face. The two were separated and Resident #13 sat back down with staff standing directly in front of him/her. A Progress Note dated 4/9/18 at 6:57 pm revealed at approximately 5:10 pm Resident #13 was sitting in a chair outside the report room with 1:1 staff supervision. All of a sudden Resident #13 bolted out of the chair and attacked Resident #8, putting him/her in a head lock/choke hold and pulling hair. Staff called for assistance and the two residents were separated. Resident #13 was sent to the local hospital for mental health treatment. Review of a summary of video surveillance documented in Resident #13's Progress Notes	R 368		

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R 368	Continued From page 2 on 4/10/18 revealed on 4/8/18, Resident #13 was sitting in the hallway outside of the staff report room while staff was providing 1:1 from the report room. At 8:23 am Resident #6, who had been lingering in the hallway area, approached the report room. Resident #13 went after Resident #6. Staff K came out of the report room to respond to the situation. She and Staff M got Resident #13 back in the chair. Staff K gave the resident a PRN medications and Staff M provided 1:1 supervision while staying in arm's length of the resident. The summary review of the video surveillance regarding the incident on 4/9/18 indicated Resident #13 pacing in the hall outside the report room at 5:04 pm. Staff L was leaning against the wall. Resident #3 sat in a chair in the same area (Note: Resident #3 was also on 1:1 supervision at this time). Resident #8 walked towards Staff L to talk to her. As Resident #8 was leaving, Resident #13 ran up to him/her and placed Resident #8 in a head lock. Resident #8 fell to the floor. Staff L immediately intervened as did Staff K who came out of the report room. Resident #13 released Resident #8 within approximately 12 seconds. Observation of the video surveillance regarding the incident on 4/8/18 revealed at approximately 8:23 am Resident #13 was sitting in a chair in the hall across from the door of the report room. Staff K is seen entering the report room. Approximately 15 seconds later Resident #6 approached the report room. Resident #13 jumped up, ran 2 to 3 feet and hit Resident #6 in the face. Staff K and Staff M came out of the report room and immediately intervened. Observation of the video surveillance regarding the incident on 4/9/18 revealed Resident #13 pacing in the hall directly outside the report room.	R 368		

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R 368	Continued From page 3 Resident #3 who was also on 1:1 supervision was sitting in a chair in the same area. Staff L was standing in the hall leaning against the wall. Resident #8 was standing a few feet away from Staff L and appeared to be saying something to the staff. As Resident #8 started to walk away, Resident #13 ran after her and placed her in a choke hold from behind. Staff L immediately tried to intervene. Other staff arrived immediately to help as well. Resident #8 was extricated from the choke hold within seconds. On 4/19/18 at 10:33 AM, Resident #3 stated he/she had been on 1:1 supervision for a few weeks. Resident #3 stated being told that staff providing 1:1 supervision were not to acknowledge the resident they were supervising and not allow them to do any pleasurable activities, such as napping. In addition, residents on 1:1 supervision were not allowed to talk to other residents. Resident #3 stated he/she spent a lot of time just sitting outside of the report room. On 4/17/18 at 11 AM, Staff K confirmed she provided 1:1 supervision to Resident #13 from the report room while he/she sat in a chair in the hallway. She stated staff had been instructed by administration in the past to not allow residents on 1:1 supervision to be entertained or allowed to feel comfortable. On 4/24/18 at 9:25 AM, Staff L stated her first day of working on the floor was on 4/9/18 and she was supposed to shadow Staff M. At some point, Staff M left her alone which put her in charge of providing 1:1 supervision to both Residents #13 and #3. Staff L stated she did not know for sure what she was supposed to do or if she was supposed to be providing 1:1 supervision to two	R 368		

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R 368	Continued From page 4 different residents at the same time on her first day. She had no knowledge of Resident #13's attacks on peers prior to the incident on 4/9/18. On 4/11/18 at 12:32 PM, the Administrator stated all facility staff including environmental, maintenance, program planners, dietary and activities were also trained to work with residents. Any staff could be called to help on the floor any time direct care staff need assistance with things such as programming, regular 2 hour head checks, dining room monitoring or 1:1 supervision. A review of the facility's "Safety Client Issues" policy on 4/24/18 addressing 1:1 supervision revealed residents could be placed on 1:1 supervision to assure safety of client or others. If that occurred, staff were to directly supervise the individual to assist with safety. The policy outlined what to do regarding removing hazardous items if necessary as well as procedures regarding bathroom usage and night time sleeping supervision. However, the policy did not indicate the following: - staff to resident distance or how monitoring was to occur - what would happen or how information would be relayed to staff if there was a special circumstance (IE more than one resident at a time on 1:1 supervision or if a resident had a no-contact order) - how staff should interact with residents on 1:1 supervision or if the resident could talk with other residents - appropriate places 1:1 supervised residents were allowed to go (IE their own room, outside to smoke, for a walk with staff, etc. - which staff were approved to provide 1:1	R 368		

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R 368	Continued From page 5 supervision On 4/24/18 at 10 AM, the Administrator and Director of Nursing confirmed the "Safety Client Issues" policy lacked appropriate directives for staff when monitoring residents on a 1:1 basis.	R 368		
R1024	481-57.34(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. interview and record review the facility failed to provide adequate supervision for 1 resident specifically (Resident #6) and all other residents in general during a 15 minute window on 3/29/18 (census of 64). Findings include: Review of Progress Notes for Resident #6 revealed a note dated 3/29/18 documenting at approximately 6:20 pm that day the resident was found standing in the hallway, doubled over and bleeding from multiple areas on the face. The resident stated three peers came to his/her room and beat him/her up. Injuries noted included a gash over the right eye, a swollen left cheek bone, a gash on the bridge of the nose and blood	R1024	Nursing department direct care staff have been retrained and only 1 staff will be in the report room at a time. 1 day shift and 1overnight staff will complete shift change report. Nursing staff will ensure 2 hour monitoring checks are complete. Alternating starting on the even/odd hour each day. Social Service staff will do an informal walk around the building, interacting with clients, checking the grounds, etc. on the opposite hours of Nursing staff checks. Social Service staff will only document if issues are noted. An all staff inservice was held On 05/02/18. Staff were retrained on safety procedure expectations and the CPI crisis developmental model was reviewed. The Nursing department orientation checklist was revised and the initial training of responsibilities has been updated.	04/03/18 04/06/18 05/02/18 04/19/18

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R1024	Continued From page 6	R1024		

coming from the mouth. There appeared to be some teeth missing. The resident was transported via ambulance to the local hospital and then air lifted to another hospital in Wisconsin.

Review of a Progress Note written by the Administrator on 4/3/18 contained a summary of her review of the video footage. Her summary noted the footage revealed Resident #3 was with Resident #6 and three other peers prior to the incident. Resident #6 walked into his/her room followed by Resident #3 and a peer. Resident #3 then exited the room with a DVD player. The other 2 peers entered the bedroom. Resident #3 went back to the room and appeared to close the door, then walk away. Approximately 2 minutes later, the 3 peers left the room and went into another room. Resident #6's roommate exited the room followed by Resident #6 at 6:15 pm.

A review of video footage dated 3/29/18 at approximately 6:13 pm revealed Residents #6, #3, #9, #10 and #12 walked to Resident #6's room (on the second floor). Residents #6, #3 and #10 entered the room. Resident #9 stood in the doorway and Resident #12 stayed in the hall leaning against the wall. After a few seconds Resident #3 exited the room with a DVD player. Residents #9 and #12 entered the room. Resident #3 appeared to shut the door and walked away. After approximately 2 minutes Residents #9, #10 and #12 left the room followed shortly by Resident #6's roommate. At 6:16 pm Resident #6 left the room with blood on his/her face and walked down the hall. No staff were observed in the area.

When interviewed on 4/4/18 at 2:46 pm, Staff H

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R1024	Continued From page 7 stated she worked until 6:00 pm on 3/29/18 but was in the report room on the first floor during the incident giving report until approximately 6:15 pm. On 4/4/18 at 1:02 pm, Staff F stated he started work at 6:00 pm on the night of 3/29/18 but was in the report room on the first floor receiving report at the time of the incident. On 4/4/18 at 12:52 pm, Staff G stated she started work at 6:00 pm on the night of 3/29/18 but was in the report room on the first floor receiving report at the time of the incident. On 4/4/18 at 6:40 pm, Staff V stated she started work at 6:00 pm on the night of 3/29/18 but was in the report room on the first floor receiving report at the time of the incident. On 4/5/18 at 12:23 pm, Staff J stated she worked until 6:00 pm on 3/29/18 but was in the report room on the first floor during the incident giving report until approximately 6:15 pm. On 4/5/18 at 2:30 pm, the Administrator confirmed there were no staff working directly on the 1st or 2nd floor during the 15 minute window allotted for giving/receiving report. The Administrator confirmed she had concerns regarding this process and the day after the incident new procedures were implemented for staff report and all staff were retrained. The new procedure included only 1 staff from first shift and 1 from second shift in the report room during shift change. The oncoming staff then communicated the report information to the staff working on the floor.	R1024		