11/20/18

PRINTED: 10/12/2018
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
	480114	A. BUILDING: _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMAGINE THE POSSIBILITIES - ANDREW JACK	18720 250TH AVENUE BELLEVUE, IA 52031

(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
R 000	Initial Comments The following deficiencies were cited during the investigation of Complaints #77783-A and #78147-A, and Incident #78545-I.	R 000	- A Suspected Abuse Reporting Form was created and will be available to all staff to use to report instances of suspected abuse to the Administrator. The Administrator will investigate all reports of suspected abuse. If the Administrator investigates and determines the complaint is valid a report will be made to the Department within 24 hours or by the next business day. - AJC will do an abuse refresher training on 12-6-18 with all staff. This training will be held annualy. - All staff will be retrained on abuse reporting procedures before 12-1-18	
R 984	481-57.32(4) Resident Abuse Prohibited 481-57.32(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. (I, II) 57.32(4) Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481-Chapter 52. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to comply with requirements regarding notification of potential dependent adult abuse found in Iowa Administrative Code chapter 235E and 481 - chapter 52 regarding 1 of 4 residents reviewed(Resident #1). Findings follow: Interviews with five staff members revealed they believed Resident #1 was being physically abused at the facility. Four staff members reported this to their supervisor. No reports of these allegations were made to the Department as required by Iowa Administrative Code Rule 481-52.2(2)a. See deficiency under 52.2(2)a.	R 984		10-31-18 12-6-18 12-1-18
D103	481--52.2(2)a Reporting Suspected Dependent Adult Abuse	D103		

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

11/13/18

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D103	Continued From page 1 52.2(2) Reporting suspected dependent adult abuse in facilities or programs. a. If a staff member or employee is required to make a report pursuant to this rule, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within 24 hours of such notification or the next business day. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report suspected dependent adult abuse to the Department regarding 1 of 4 residents reviewed (Resident #1). Findings follow: Record review on 9/13/18 revealed Resident #1 was seen by a local physician's clinic on 3/23/18 and 5/25/18 due to an injury to her left big toe. The note from the visit on 3/23/18 identified, "on exam it looks like it ' s been bumped and bruised and got a subungual hematoma." The note continued, "She was advised that I think she must have injured it and am not sure it ' s related to the prior surgery or procedure." (Resident #1 had surgery on this toe a year or two prior). A follow-up note from the clinic dated 5/25/18 noted, "At some point she apparently had an injury with a subungual hematoma." A review of the Medication Administration Record (MARS) from 3/1/18 through 8/21/18 revealed Resident #1 asked for medication for toe/foot pain on the following dates: 4/10/18, 4/13/18, 4/18/18 (x2), 5/10/18 and 8/18/18. Resident #1 was	D103	- The abuse reporting procedure will be posted in the AAC display case and also in the DSP station - Copies of the abuse reporting form will be stored in the DSP forms binder so staff have access to them. - All AAC staff will be retrained in API on a 6 month basis, beginning in December 2018 Thank you.	10-31-18 10-31-18 1-1-19

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D103	Continued From page 2 discharged from the facility on 8/22/18. Interviews conducted from September 12 - 20, 2018 revealed the following: - Staff B witnessed Staff A step on Resident #1's foot once. Staff B also heard Staff A swear at Resident #1 and threaten to step on Resident #1's foot. Staff B stated she reported this to the Associate Administrator. - Staff C reported concerns Staff A and Staff F were stepping on Resident #1's toes. Staff C reported Staff A, Staff F and Staff J had threatened to step on Resident #1's toes. Staff C reported these concerns to the Associate Administrator. Staff C reported she witnessed the Associate Administrator shove Resident #1 into the wall and swear at her on 8/21/18. - Staff D saw Staff F pull Resident #1 from a standing position to the floor by her hair. Staff D also saw Staff A and Staff E purposely step on the injured toe of Resident #1 when Resident #1 wouldn't do what they wanted her to do. Staff D saw Staff J step on Resident #1's foot once. Staff D reported these concerns to the Associate Administrator, but was told Resident #1 was a liar. Staff D said there was a message on the facility computer which said, "if you see something, say something." Staff D said she did this and nothing was done. - Staff E reported she saw a staff person "body slam" Resident #1 on 8/11/18 when Resident #1 was preventing Staff E from exiting the building. Staff E did not report these concerns to the Administrator until 9/19/18. Staff E reported she knew legally she should have made this report but said morally, she did not know if it was the right thing to do. - Staff H saw Staff A purposely step on the injured toe of Resident #1. Staff H also heard	D103		

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D103	Continued From page 3 Staff A threaten to step on the toe of Resident #1 twice. Staff H did not report this to administration as she believed they would not do anything about the abuse. No reports were made to the made to the Department with these concerns. On 9/18/18 at 12:40 p.m. the Associate Director stated no one had reported any allegations of abuse to her regarding Resident #1.	D103		