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
	890403	A. BUILDING: _____ B. WING _____ 3/13/19	02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER VILLAGE OF TENCO	19248 MAPLE AVENUE KEOSAUQUA, IA 52565

(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 survey conducted to determine compliance with licensing rules for a Residential Care Facility.	R 000		
R 266	481-57.7(5)b General Requirements 481-57.7(135C) General requirements. 57.7(5) The licensee shall: b. Be responsible for compliance with all applicable laws and with the rules of the department. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to comply with requirements related to notification 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 an elopement as required by Iowa Administrative Code rule 50.7(4). The administrator confirmed this finding. See deficiency under 50.7(4) for details.	R 266		
R 616	481-57.17(1)o Records 481-57.17(135C) Records. 57.17(1) Resident record. The licensee shall keep a permanent record on every resident admitted to the residential care facility, and all	R 616	Plan of Correction is attached DD 3/13/19	

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

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R 616	Continued From page 1 entries in the permanent record shall be current, dated, and signed. (III) The record shall include: o. A notation describing the resident's condition on admission, transfer and discharge; (III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure condition upon discharge was documented for 5 of 5 former residents reviewed (Residents C-1, C-2, C-3, C-4 and C-5). Findings follow: Record review on 2/13/18 of files for residents who had been discharged from the facility revealed the following: - Resident C-1 was discharged from the facility on 2/4/18. There was no documentation of the resident's condition upon discharge. - Resident C-2 was discharged from the facility on 7/5/18. There was no documentation of the resident's condition upon discharge. - Resident C-3 was discharged from the facility on 8/20/18. There was no documentation of the resident's condition upon discharge. - Resident C-4 was discharged from the facility on 9/25/18. There was no documentation of the resident's condition upon discharge. - Resident C-5 was discharged from the facility on 10/31/18. There was no documentation of the resident's condition upon discharge. An interview with the Area Director on 2/13/18 at 12:50 PM confirmed these findings.	R 616		

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R 746	Continued From page 2	R 746		
R 746	481-57.19(4)c(1) Drugs 481-57.19(135C) Drugs 57.19(4) Drug administration. c. A resident certified by the resident's primary care provider as capable of injecting the resident's own insulin may do so. Insulin may be administered pursuant to paragraph 57.19(4)" b " or as otherwise authorized by the resident's primary care provider. (II, III) Authorization shall: (1) Be in writing This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 2 of 2 residents who injected their own insulin had been certified by the primary care provider to do so (Residents #2, #4). Findings follow: During an observation of a medication pass on 2/13/19 at 11:15 AM, Resident #2 and Resident #4 were seen injecting their own insulin. Record review on 2/13/19 revealed signed physician's orders for Resident #2 and Resident #4 dated 1/11/19. The physician had not authorized either resident to administer their own insulin. Staff A was interviewed on 2/13/19 at 12:35 PM. Staff A was responsible for obtaining medication	R 746		

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R 746	Continued From page 3 orders for Resident #2 and Resident #4 from their physician but did not know she also needed to get an order for them to administer their own insulin. Staff A did obtain written orders certifying Resident #2 and Resident #4 were cable of administering their insulin on 2/13/19.	R 746		
R 828	481-57.22(3) Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure assessed needs were addressed on the Individual Program Plan for 1 of 4 residents reviewed (Resident #1). Findings follow:	R 828		

DEPARTMENT OF INSPECTIONS AND APPEALS

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R 828	Continued From page 4 Record review on 2/13/19 revealed a Critical Incident Report dated 11/24/18. At 7:30 PM, staff were unable to locate Resident #1 in the facility after searching the building and grounds. Staff called the Sheriff's Office at 8:30 PM to inform them Resident #1 was missing. The Sheriff's deputy and facility staff found the resident at a bank 2.2 miles away from the facility and returned her to the building at 9:15 PM. Resident #1's Individual Program Plan, dated 10/31/18, identified Resident #1 "becomes very delusional, can be an elopement risk and/or having visual/auditory hallucinations." On 2/14/19 at 10:50 AM the Area Director reported Resident #1 was at a Transition House prior to being admitted to the facility. The Area Director stated Resident #1 tried to leave the Transition House while living there. Upon her admission to the facility, Resident #1 often talked about wanting to leave the facility with her sons. The Area Director confirmed Resident #1 did not have a goal to address her risk of eloping from the facility.	R 828		
R 834	481-57.22(3)c Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and	R 834		

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R 834	Continued From page 5 social, behavioral, emotional, physical and mental health. (I, II, III) c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to modify Individual Program Plans upon a change in condition for 1 of 3 residents reviewed (Resident #1). Findings follow: Record review for Resident #1 on 2/12/19 revealed an Individual Program Plan dated 10/31/18. Resident #1 had a goal to improve her mental health with an action step to take all scheduled medications as outlined in her mental health committal with the assistance of staff. According to Critical Incident Report Forms, Resident #1 refused her medication on the following dates: 11/22/18, 11/29/18, 11/30/18 (twice), 12/1/18, 12/2/18, 12/3/18 (twice), 12/4/18, 12/5/18, 12/6/18, 12/8/18, 12/9/18, 12/10/18, 12/11/18, 12/12/18 and 1/17/19 (twice). An interview conducted with the Area Director on	R 834		

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R 834	Continued From page 6 2/13/19 at 2:20 PM revealed Resident #1 was hospitalized from 12/17/18 to 1/2/19 as a result of not taking her medication. The Area Director confirmed Resident #1's Service Plan was not updated to specifically address the behavior of medication refusals.	R 834		
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 failed to report an elopement to the department on the next business day following the elopement. Findings follow: Record review on 2/12/19 revealed a Critical Incident Report dated 11/24/18. According to the document, Resident #1 eloped from the facility at 7:30 PM on that date. Staff searched the building and facility without locating the resident. The Sheriff's Department was at 8:30 PM. Resident #1 was located 2.2 miles from the facility at a local bank and was returned to the facility at 9:15 PM. During an interview with the Chief Operating	C 147		

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C 147	Continued From page 7 Operator on 2/12/19 at 1:15 PM, she confirmed the incident was not reported to the department.	C 147		

✓ 3/13/19

PLAN OF CORRECTION

Provider Name:	Center Village of Tenco
Street Address, City, Zip:	19248 Maple Ave. Keosauqua, IA 52565
Date Survey Completed:	February 12, 2019 – February 14, 2019

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	890403

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
R000	Initial Comments The following deficiencies were cited during the survey conducted to determine compliance with licensing requirements for a Residential Care Facility.	NA
R 266	481-57.7(5)b General Requirements 481-57.7(135C) General Requirements. 57.7(5) The licensee shall: b. Be responsible for compliance with all applicable laws and with the rules of the department (I, II, III) ***Refer to deficiency under 50.7(4) for detailed corrective action.***	NA
R 616	481-57.17(1)o Records 481-57.17(135C) Records 57.17(1) Resident Record. The licensee shall keep a permanent record on every resident admitted to the residential care facility, and all entries in the permanent record shall be current, dated, and signed. (III) The record shall include: o. A notation describing the resident's condition on admission, transfer, and discharge; (III) ***Upon discharge from Center Village of Tenco, the resident's physical, emotional, and mental condition will be documented (based on staff observation and discussion with the resident) in the resident's written discharge summary. Tenco's Operations team will discuss and implement this change by March 12, 2019 through an update to the current "Discharge Summary" form utilized on the date of discharge.***	March 12, 2019

3/13/19

R 746	481-57.19(4)c(1) Drugs 481-57.19(135C) Drugs 57.19(4) Drug Administration. c. A resident certified be the resident's primary care provider as capable of injecting the resident's own insulin may do so. Insulin may be administered pursuant to paragraph 57.19(4)b or as otherwise authorized by the resident's primary care provider. (II, III) Authorization shall: (1) Be in writing ***Center Village of Tenco will obtain written authorization, from the resident's primary care provider, for all resident's who inject their own insulin. This documentation will be reviewed and renewed at least quarterly and maintained in the resident's medical chart.***	Corrected 2/13/19
R 828	481-57.22(3) Orientation and Service Plan 57.22(3) Service Plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social behavioral, emotional, physical, and mental health ***Center Village of Tenco staff meet at least monthly. The Area Director for Center Village of Tenco will incorporate "review of resident patterns/trends" as an agenda item during these meetings to discuss any needs to review and/or revise resident plans as patterns or trends are identified. In addition, Center Village of Tenco's Team Leader will continue to review daily service documentation at least weekly and report necessary information to the Area Director for review.***	First staff meeting will be in March 2019 Documentation review is effective immediately
R 834	481-57.22(3)c Orientation and Service Plan 57.22(3) Service Plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social behavioral, emotional, physical, and mental health. (I, II, III) c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party (I, II, III)	

R 834 continued	***Center Village of Tenco staff meet at least monthly. The Area Director for Center Village of Tenco will incorporate "review of resident patterns/trends" as an agenda item during these meetings to discuss any needs to review and/or revise resident plans as patterns or trends are identified. In addition, Center Village of Tenco's Team Leader will continue to review daily service documentation at least weekly and report necessary information to the Area Director for review.*** ***Any identified needs for change to the resident's Service Plan goals or objectives will be immediately communicated, by the Area Director, to all persons involved in the resident's care. These changes will be communicated in the most expeditious means possible and will also be written as amended goals in the resident's record.***	Effective immediately
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 eloped from a facility, For the purposes of the subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. ***Center Village of Tenco did fail to report an elopement that occurred on 11/24/18 due to miscommunication between on-shift staff, on-call Chief Operations Officer, and on-site Team Leader. Center Village of Tenco administration and staff have reviewed the department's reporting criteria for Residential Care Facilities as well as internal processes for communicating situations/incidents that occur with residents at the facility In addition, Tenco's internal incident reports are submitted to the Chief Operations Officer, prior to final filing, and will be reviewed to ensure all reports are made in accordance with department guidelines.***	Effective immediately