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 04/09/2019

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 During investigation #82162-I, deficiencies were cited at W249 and W368.	W 000		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure clients received identified supports and services as outlined in the Individual Support Plan (ISP). This affected 1 of 1 Client (Client #1) reviewed during investigation #82162-I. Finding follows: Record review on 4/8/19 revealed the facility's Incident Summary Sheet, dated 3/19/19 at 8:20 PM documented Client #1 sat at a table eating a snack. Client #1 ate a vanilla cookie and drinking Kool-Aid (pudding/honey consistency). Two staff sat with Client #1 and another client. Client #1 began to cough. Resident Living Assistant (RLA) A asked Client #1 if he was choking and he did not respond. The client's lips began to turn purple, his eyes watered and he gasped for air. RLA A began to administer the Heimlich procedure on the client and he began to breath. Client #1 stated he ate too fast and took	W 249	See attached POC 6/7/19	

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 249	Continued From page 1 too many bites. The Summary noted, "(RLAA) mentioned that Client #1 was given the cookies whole, but (Client #1) was taking bites." Continued record review revealed an Interdisciplinary Progress Note written by the facility's Registered Nurse (RN) on 3/19/19 noted the client's lungs sounds were clear (all lobes). He was oriented x4 and there was no redness or bruising to the abdomen. Staff were instructed to continue to monitor the client for bruising. According to a Physician Form, Client#1's diagnosis's included: mild intellectual disability, cerebral palsy, psychotic disorder not otherwise specified (NOS), removal of most of large intestine due to bowel impaction, history of aspiration and dysphagia. The form indicated Client #1's diet as follows: general, mechanical soft with nectar consistency liquids, ground meat, bites size pieces for all foods. Record review revealed Client#1's ISP included an Annual Dietary Report, dated 3/20/18. The report documented Client #1's diet included a "bland dysphagia level 3 diet with nectar thickened liquids." An Occupational Therapy Report, dated 3/20/18, noted Client #1 utilized a smaller utensil to manage his bite size requirement and supervision was provided for pacing. When interviewed on 4/8/19 at 3:20PM, the Dietary Supervisor and Administrator showed the location of a communication book, which included the information regarding Client #1's requirement of eating only food in bite size pieces. The book was located in the facility's kitchen. They both stated all staff were aware of the location of the	W 249		

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W 249	Continued From page 2 communication book. The Dietary Supervisor stated on the evening of the incident, direct care staff were giving out snacks instead of dietary staff. She noted they were short staffed that day. The supervisor indicated regardless of who gave out snacks, staff should have known Client #1 was to have only bite sized pieces of food. The Administrator noted, after the 3/19/19 incident, all staff were retrained on Client #1's diet order. When itnerviewed on 4/8/19 at 2:15PM, RLA A stated she passed out snacks to clients on 3/19/19 and Client #1 received a vanilla cream wafer instead of a fig newton. She recalled staff telling her Client #1 was choking and she then applied the Heimlich procedure on the client. She remarked the client did not expel the wafer, but began breathing on his own. RLA A stated she was not aware of the location of the communication book which indicated Client #1's requirement for bite sized pieces of food. She said she was not sure she had been informed that Client #1 was to eat only bite sized pieces of food. According to RLA A, Client #1 had received the wafers at prior snack times and had no problems ingesting them.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to administer medications in compliance with physician orders. This affected 1	W 368		

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W 368	Continued From page 3 of 1 Client (Client #2) reviewed during investigation #82162-I. Finding follows: Record review on 4/8/19 revealed an Incident Summary Sheet, dated 3/21/19 at 6:30 a.m., written by Certified Medication Aide (CMA) B, stated " I had just crushed Client #3's AM meds and was asked to check Client #2's ostomy bag, set down med cup on counter with med cards. Got Client #2s meds crushed and turned to grab pudding put it in wrong med cup. Left to see Client #2 and gave her meds in my hand, came back to med room realized I gave wrong meds and called RN (registered nurse)." Continued record review revealed a Physician Fax Form, dated 3/21/19, noted Client #2 received another client's medications that morning. The physician was notified at 6:30 a.m. and gave orders to monitor the client. At 8:00 a.m., Client #2's blood pressure dropped to 80/50 and she was non-responsive. The physician then gave the ok to go to the emergency room via ambulance. While at the ER tests were run, fluids were given via IV and a CAT scan and chest X-ray were completed. As of noon, the client was released from the ER and returned to Park View Homes. Nurse retraining was completed and the issue was addressed at a full nursing meeting. A 3/21/19 Interdisciplinary Progress Note written by the Facility's RN noted the physician was called because Client #2 received another client's medication. The physician said not to give Client #2 her medications and to monitor her. The RN noted Client #2 became very drowsy and her blood pressure dropped. 911 was called and Client #2 was taken to the hospital, where she	W 368		

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W 368	Continued From page 4 had her blood drawn, had a chest x-ray and had a CT scan. All tests reportedly came back normal. The client was discharged from the hospital at noon that day. According to Client #2's Physician Form, Client #2's current a.m. medications included: Phenobarbital, Keppra, Multivitamin, Vitamin C, Ranitidine, Calcium, Vitamin B6, Aspirin and Lipitor. According to Client #3's Physician Form, Client #3's current a.m. medications (medications Client #2 received on 3/21/19) included: Clozaril, Clonidine, Ativan, Prilosec, Tums, Multivitamin, Cogentin and Depakote. Record review revealed Client #2's After Visit Summary from her Emergency Room visit on 3/21/19. According to the When interviewed on 4/9/19 at 8:30 a.m., CMA B stated she accidentally gave Client #3's medication to Client #2. She stated she crushed Client #3's medication and became distracted when staff asked her to check Client #2's ostomy bag. She then crushed Client #2s medications, went to see Client #2 and administered the medications to her. CMA B reported she went back to the medication room and realized she gave Client #3's medications to Client #2. CMA B said she immediately called the facility's LPN. CMA B stated Client #2 became drowsy and was slumping in her chair. Her blood pressure became low and 911 was called. CMA B said the Client returned to the home at approximately noon that day with no apparent ill effects. She offered she was disciplined and was retrained on proper medication administration procedures.	W 368		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OK
6/3/19
6/5/19

Park View Homes-Plan of Correction

Citation #: 6968

W-249 Employees were retrained on member diets, where special diets are posted and where the Dietary communication log is located.
Date completed-3/30/2019

W-368 All nurses and certified med aides were retrained on the correct procedure to pass medications. They were instructed that medications cannot be set up in advance and Director of Nursing is monitoring to ensure compliance.
Date completed-4/3/2019

W-249 Member diets will be reviewed with staff. All staff will be aware of where communication addressing special diet orders are located. Information will be shared at meetings, on the job training and new employee orientation.
Responsible: Dietary Manager, QIDPs and Residential Supervisors
Frequency: Daily
Completion Date: June 7, 2019

W-368 Medications will be administered in compliance with physician orders. Employees will continue to receive training on medication administration through observation and at meetings.
Responsible: Director of Nursing and Administrator
Frequency: Daily
Completion Date: June 7, 2019

Leslie Ritchie, Administrator
Park View Homes