

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

PRINTED: 05/29/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16F001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/13/2019
NAME OF PROVIDER OR SUPPLIER DAVIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 22425 OVERLAND AVENUE BLOOMFIELD, IA 52537		
(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
F 000	INITIAL COMMENTS The following deficiency relates to the investigation of incident #81683. (See Federal Code of Regulations (42-CFR) Part 483, Subpart B-C).	F 000			
F 689 SS=J	The "J" level deficiency issued at F689 was corrected on March 1, 2019, prior to surveyor entrance, therefore it will be considered past non-compliance. There will be no onsite revisit and no plan of correction is required. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This deficiency relates to self reported incident 81683-I. Based on record review and staff interviews, the facility failed to provide adequate supervision of a resident in the community resulting in an elopement. (Resident #1) The facility reported the census of 28 residents. Findings include: According to the Minimum Data Set (MDS) assessment with assessment reference date of	F 689	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

05/29/2019

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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F 689	Continued From page 1 3/4/19, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 indicating severely impaired cognitive skills for daily decision making. Resident #1 is independent with mobility, transfers, dressing, toilet use and personal hygiene. Resident #1's diagnosis included Non-Alzheimer's dementia and schizophrenia. Resident #1 resides in a locked residential care facility and is court committed to the facility. In an interview on 5/9/19 at 3:06 p.m. Staff A, activity assistant, stated on 2/26/19, Resident #1 had a doctors appointment at the hospital. Following the appointment, Staff A stopped by a physician's office to get some orders signed. Staff A told Resident #1 to wait in the van and she would be right back. Resident #1 stated she would be fine and Staff A proceeded into the physician's office. Staff A stated about two minutes later she returned to the van and Resident #1 not there. Staff A stated she looked down the alley and didn't see anyone so she returned into the physician's office to ask if Resident #1 may have came in. The front indicated they had not seen Resident #1 and Staff A returned to the van and drove around the block. Staff A then received a call from her supervisor, Staff B, asking if she had found Resident #1. Staff B stated the physician's office had called and reported seeing Resident #1 walking in the alley. Staff A stated she saw a gas station and thought Resident #1 may have went there to get cigarettes. As Staff A pulled into the parking lot, Resident #1 was walking out the gas station door. Resident #1 stated she was fine and needed to use the bathroom. Staff A stated she has left residents in the van before when needing to go in	F 689			

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F 689	Continued From page 2 for something quickly and stated her supervisor has approved this practice for residents who can be trusted, for only a short amount of time. Staff A stated the entire incident lasted about 10 minutes. Staff A stated Resident #1 has been taken to events in the community, but has always been supervised. In an interview on 5/9/19 at 4:07 p.m. Staff B, Activity Director, stated she has never instructed anyone that it is acceptable to leave a resident unattended in the van, while staff run in and out for an errand. Staff B stated she has never left a resident unattended in the van herself and Resident #1 would be someone she would never leave unattended in the community. According to the Minimum Data Set (MDS) assessment with assessment reference date of 1/29/19, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 indicating an intact cognitive skills for daily decision making. Resident #3 is independent with mobility, transfers, dressing, toilet use and personal hygiene. Resident #3's diagnosis included schizophrenia. Resident #3 resides in a locked residential care facility. In an interview on 5/13/19 at 9:22 a.m. Resident #3 stated there have been times in which staff has left him in the van unattended while staff runs in somewhere to do something. Resident #3 stated maybe 4-5 minutes and it was no big deal. In an interview on 5/9/19 at 4:38 p.m. Staff C, social worker, stated he has been involved with taking residents into the community and stated	F 689			

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F 689	Continued From page 3 residents should never be left out of line of sight. Staff C stated Resident #1, as with all other residents, should be supervised when in the community. In an interview on 5/9/19 at 4:15 p.m. Staff D, assistant director of nursing, stated they are a locked facility and she wouldn't feel comfortable with any resident being left unattended in the community. Staff D stated Resident #1 on most days is alert and rational, but there may be other times she isn't and could pose a greater risk for herself if left unattended. Staff D stated she was the one that asked Staff A to drop off physician orders, but noted she thought Resident #1 had an appointment at that office. Staff D stated since the incident they have now changed tasks like these to be done by someone other than who has residents with them. In an interview on 5/9/19 at 4:30 p.m. the Administrator stated she was not aware of any orientation training which specifically addressed prohibiting the practice of leaving residents unattended in the community. Since the incident involving Resident #1 on 2/26/19, all staff have been educated on not leaving residents unattended and this expectation was added to the facilities elopement policy. The immediate jeopardy was abated on 3/1/2019 when all staff were educated on elopement policy and prohibiting residents being left unattended in the community. According to the facilities Missing or Runaway Resident policy under Transportation: If staff are transporting a resident, the resident should not be left unattended at any time.	F 689			

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