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 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HOMES	2815 LINCOLN WAY SIOUX CITY, IA 51106

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W 000	INITIAL COMMENTS At the time of the annual survey deficiencies were cited at W234 and W 339. During the annual survey investigation # 87739-I was completed. Deficiencies were cited at W 104 and W 368.	W 000	See attached POC 4/7/2020	
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the governing body failed to ensure consistent follow up to an approved plan of correction for Incident Investigation #82162-I. This affected 44 of 44 clients (Client #1 - Client #44). Finding follows: Record review on 1/6/20 revealed a facility incident report and an investigation for a medication error on 1/1/2020. The reports revealed Client #15's medications were given to Client #14 during the a.m. medication pass on 1/1/20. Client #14 went to the medication room and took medications around 7:15 a.m. from Registered Nurse (RN) A. Just prior to Client #14 taking his medications, Client #15 had set up his medications in the med room but left without taking them. Client #15 left them in a cup on the counter in the med room. RN A realized Client #14 likely took Client #15's medications approximately 15-25 minutes later when Client #15 came to the medication room asking for his medications he previously set up. RN A stated	W 104		

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 104	Continued From page 1 Client #14 took Client #15's medications which included Folic Acid, Multivitamin, Primidone, Clozapine, Iron, Prozac and Wellbutrin. Around 8:00 a.m. RN A was called to the dining room where Client #14 was seated for breakfast. Client #14 appeared lethargic and did not act like himself. RN A called RN B from another house to come and provide assistance. When she arrived and tried to talk to Client #14 he slumped over on the table. RN A informed her Client #14 may have got Client #15's medications earlier that morning. RN B attempted to call the physician for guidance, but when she did not immediately answer she called 911 and had Client #14 transported to the Unity Point Emergency Room via ambulance. Record review on 1/8/20 revealed a previous medication error occurred on 3/21/19 and was investigated on 4/9/19 by The Department of Inspections and Appeals (DIA). DIA cited a deficiency at W368 for the medication error and the facility submitted a plan of correction. The Department accepted the facility proposed plan of correction, which required the DON would be responsible to monitor and ensure the plan was followed. The plan stated: Medications will be administered in compliance with physician orders. Employees will continue to receive training on medication administration through observation and at meetings. The facility failed to follow the plan of correction and did not complete the monitoring and training agreed upon by DIA. When interviewed on 1/8/20 at 9:20 a.m. the Director of Nursing (DON) stated RN A had a previous error and supervisory notation dated 9/17/18. The clarification of expectations described an incident on 9/12/18 when RN A gave	W 104		

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W 104	Continued From page 2 the wrong client the wrong medication. RN A gave 150 mg of Clozaril to the wrong client on 9/12/18 and the client was taken to Unity Point ER for treatment. When asked about the facility incident investigation #82162-I investigated on 4/9/19, the DON confirmed the facility had agreed to the plan of correction. The DON confirmed she only conducted four observations since the 6/7/19 plan of completion date. She admitted she should have completed more than four observations of staff as they administered medications. When interviewed on 1/8/20 at 3 p.m. the Administrator stated the expectation is that the DON would continue to monitor, observe and train all staff who administered medications. She also confirmed more than four observations of medication passes should have been completed according to the facility plan of correction from the investigation dated 4/9/19. She confirmed the facility failed to follow the plan of correction as written.	W 104		
W 234	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(i) Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure client programs were written with sufficient information to ensure all staff consistently implemented the procedures as written. This affected one client (Client #5) in House #1 sent to the emergency room for stitches/staples on multiple occasions	W 234		

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W 234	Continued From page 3 since the last annual survey. Findings follow: Observations on 1/7/2020 at 4:20 p.m. revealed Client #5 as he paced non-stop through the kitchen, living room and halls of House #1 with his helmet on. Client #5 never became involved in an activity as he walked around without an apparent destination/purpose. At 4:30 p.m. Qualified Intellectual Disabilities Professional (QIDP) B said something to him and pointed to the living room area. This happened twice between 4:30 p.m. and 4:35 p.m. when the observation ended. When interviewed on 1/8/2020 at 10:30 a.m. QIDP B confirmed he told Client #5 to sit down on the couch twice the day before about 4:30 p.m. during this writer's observation. He confirmed he followed Client #5's "safety procedure" when he asked him to sit down and other staff should be doing the same. Additional observation on 1/9/2020 at 8:10 a.m. revealed Client #5 as he paced around House #1 without his helmet on. At 8:15 a.m. Residential Living Assistant (RLA) A escorted Client #5 to his room where they retrieved his helmet. At 8:15 a.m. Client #5 returned to the main living/dining area and paced without an apparent purpose or destination until the observation ended at 8:45 a.m. During this thirty minute observation staff failed to interact with the client despite numerous staff in and out of the area. Record review on 1/8/2020 revealed a document titled "Seizure Summary" for Client #5. The summary covered all twelve months during 2019 and revealed the client had a total of 14 seizures during the year. Eleven of the seizures happened	W 234		

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W 234	Continued From page 4 between March and September of 2019. Continued record review revealed numerous documents titled "Member Injury Report" (MIR) related to Client #5. These documents revealed the client fell numerous times between March 2019 and September 2019. Several of these falls resulted in emergency room visits and stitches/staples to the clients head. Including: a. MIR dated 3/8/2019 revealed Client #5 had a seizure and fell in the dining room. The client hit his head on the way down which resulted in a "2 inch gash to (right) temporal area with intense bleeding." Facility staff called 911 and the client received sutures at the emergency room (ER). QIDP B noted in the section titled "Actions to be taken to reduce potential for further injury" the client needed to be monitored while ambulatory and encouraged to sit down. The document failed to indicate whether or not the client had a helmet on at the time of the fall. b. MIR dated 6/1/2029 at 8:05 p.m. revealed Client #5 had a seizure and fell hitting his head on the wall. The document noted Client #5 did not have his helmet on. Assessments revealed the client appeared not to have any injuries related to the fall, but nursing staff began neurological checks. QIDP B noted to reduce further injury the team would be retrained to ensure the client had his helmet on. c. MIR dated 6/20/2019 at 8:20 p.m. revealed Client #5 had a seizure and fell backwards to the floor with his helmet on. The document indicated the client had redness to the back of his head, but no further injuries. QIDP B again noted Client #5 needed to be monitored when up and walking	W 234		

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W 234	Continued From page 5 around. d. MIR dated 8/23/2019 at 8:45 p.m. revealed Client #5 had a seizure which caused him to fall to the floor. The client bit his tongue and had a gash in the back of his head. The document indicated the fall was not witnessed by staff and the client and the client did not have his helmet on. The client was taken to the ER by physician order where he received staples to his head. QIDP B indicated staff would be retrained on the client wearing his helmet and a program revision. e. MIR dated 9/11/2019 at 7:35 p.m. revealed Client #5 had a seizure and fell in the hallway without his helmet and received a 2 inch laceration to his head. The document indicated a moderate amount of blood from the occipital area and the client was sent to the ER where he received three staples in his head. QIDP B indicated staff needed to continue to monitor the client, have him remain seated and keep his helmet on. He also indicated they purchased a new helmet and hoped Client #5 would keep it on. f. MIR dated 9/23/2019 at 8:40 p.m. revealed Client #5 had a seizure and fell on the floor. The client did not have his helmet on and reopened a previous laceration. QIDP B noted a modification would be made to the helmet, but staff needed to prompt client to wear it. Additional record review on 9/8/2019 revealed a "Helmet Procedure" and a "Safety Procedure" related to Client #5's falls during seizures. The "Helmet Procedure," initiated 3/21/2019 and last updated 6/24/2019, revealed it would be used "To protect (Client #5) from injuries, which can result from falls." Point #2 indicated Client #5 was	W 234		

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PARK VIEW HOMES	2815 LINCOLN WAY SIOUX CITY, IA 51106

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W 234	Continued From page 6 "required to wear a protective helmet while he is at the home (Park View) and also at Southgate (work site)." The program further required the helmet to be worn "when standing or ambulating." The client did not have to wear the helmet when showering, sleeping or on a community outing. If staff found Client #5 at Park View or Southgate without the helmet on they needed to retrieve it and apply it ensuring it was fastened and secure. The "Safety Procedure," dated 8/6/2016 ,indicated the client had a seizure disorder which led to falls when he walked and paced around his environment. Point #1 indicated staff needed to direct Client #5 to sit down in a group setting anytime he walked aimlessly without a destination. Point #2 instructed staff to redirect and monitor the client if he continued to wander around the area after being initially asked to sit down. Point #3 indicated all team members were responsible for monitoring the client to ensure he's being redirected to sit down. Four facility staff were interviewed on 1/9/2020 after they were observed working in the area with Client #5, including RLA A, RLA B, RLA C and Residential Supervisor B. All four were asked what procedures were in place to keep Client #5 safe from falls during seizures. The four staff all reported they needed to ensure the client had his helmet on. The staff were asked about any other procedures in place and they indicated they were only aware of having him wear the helmet. None of the staff mentioned supervision/monitoring the client or redirecting his to a seated position. When interviewed on 1/9/2020 at 9:00 a.m. the Administrator read the "Safety Procedure" for Client #5. The surveyor informed her of the	W 234		

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PARK VIEW HOMES	2815 LINCOLN WAY SIOUX CITY, IA 51106

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W 234	Continued From page 7 observation that took place earlier in the morning from 8:10 a.m. to 8:45 a.m. where staff provided Client #5 his helmet, but failed to interact with, monitor or direct the client to sit down as the program dictated. The Administrator confirmed staff failed to follow the program as written. The surveyor also asked the Administrator what it meant to "monitor" Client #5 as written in the "Safety Procedure" program and she admitted the program failed to clearly define what it meant. When interviewed on 1/9/2020 at 1:00 p.m. QIDP B confirmed staff should have interacted with, monitored and instructed Client #5 to sit down during the observation that morning from 8:10 a.m. to 8:45 a.m. The surveyor also went through the "Safety Procedure" with QIDP B who admitted the procedure failed to clearly define how staff needed to monitor Client #5 if he didn't sit down. He also indicated concern all four staff interviewed earlier that morning were made no mention of monitoring the client as written in the "Safety Procedure" when asked how to keep Client #5 safe from falls. He acknowledged the client had less seizures/falls the last few months, but indicated supervision of Client #5 needed to be clearly defined in the procedure to help prevent future injuries.	W 234		
W 339	NURSING SERVICES CFR(s): 483.460(c)(4) Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on observations, interviews and record	W 339		

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	16G023	A. BUILDING _____ B. WING _____	C 01/09/2020

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W 339	Continued From page 8	W 339		

reviews the facility failed to consistently ensure nursing care met identified client medical needs. This affected 2 of 4 sample client (Client #26 & Client #34). Findings follow:

1. Observations on 1/6/2020 at 4:55 p.m. revealed Client #34 at the table for dinner. Residential Supervisor (RS) A prompted the client to pour liquids into his cups. Client #34 struggled due to very shaky hands (tremors) and RS A assisted him with hand over hand (HOH) assistance to avoid spills.

Review of Client #34's record on 1/8/2020 revealed a document titled "Medication Side Effects" for the medication Clozaril. The document listed many possible side effects of the medication which included tremors. Further review of the document revealed it had been filled out from January 2019 through November 2019 for observed side effects seen from Client #34. The only side effects listed for the 11 month period were sedation and constipation.

When interviewed on 1/8/2020 the Qualified Intellectual Disabilities Professional (QIDP) A confirmed she witnessed Client #34's hand tremors frequently for at least the last 6 months. She also confirmed the tremors should be listed on the side effects document so the physician could be made aware.

When interviewed on 1/9/2020 at 9:00 a.m. the Director of Nursing (DON) confirmed the facility used the document to communicate side effects experienced by the client to the physician. She confirmed the signature for the last 6 months on the document as Registered Nurse (RN) A. She also confirmed if Client #34 experienced tremors

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PARK VIEW HOMES	2815 LINCOLN WAY SIOUX CITY, IA 51106

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W 339	Continued From page 9 it should have been on the document otherwise the physician would not know about the tremors unless he/she noticed them. She admitted nursing staff failed to document the observed side effect and could not be sure if the physician was aware of the side effect or not. 2. Observations on 1/6/2020 at 3:54 p.m. revealed Client #26 with nursing staff by the medication room. Client #26 had a blood pressure monitor on her wrist. They tried for several minutes to take her blood pressure but the machine failed each time. They decided to try again later. Review of Client #26's record on 1/8/2020 revealed pharmacy review document submitted for the 30 day Individual Program Plan (IPP) signed and dated by the pharmacist 5/28/2019. The document recommended facility staff take Client #26 blood pressure every week with "Guanfacine therapy." The document listed Guanfacine 1-1.5 mg as a medication taken by the client daily. Further record review of the 8/2019 and 11/2019 pharmacy reviews for Client #26 continued to recommended weekly blood pressure readings for the client "if not already being done" as the client remained on Guanfacine. Review of Client #26 records found blood pressure readings did not start until five months later in October 2019. When interviewed on 1/8/2020 the DON confirmed she missed the recommendation and failed to have nursing staff start blood pressure readings for Client #26 until 10/2019. 3. Review of Client #26 records revealed she	W 339		

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W 339	Continued From page 10 arrived at Park View Homes on 4/15/2019 from another Intermediate Care Facility. Review of a "Medical Report" from the previous facility revealed Client #26 had been diagnosed with high cholesterol on 12/17/2018 and recommended a low fat diet. Review of numerous records for Client #26 developed at Park View Homes failed to mention anything about the high cholesterol or a low fat diet. Client #26 received a dietary evaluation on 5/9/2019 which revealed she was on a regular diet with skim milk. When interviewed on 1/8/2019 at approximately 12 p.m. the DON confirmed she had "missed the recommendation" and had no idea the client had a history of high cholesterol. She indicated she would notify the physician right away to get a blood/lipids test to check on the cholesterol.	W 339		
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 according to with physician orders. This affected 1 of 1 Client (Client #14) reviewed during investigation #87739-I. Finding follows: Record Review on 1/6/20 revealed a Medication Incident Report, dated 1/1/20 at 7:00 a.m., written by Registered Nurse (RN) A. The report noted "Client #15 called to the med room for meds, I	W 368		

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PARK VIEW HOMES	2815 LINCOLN WAY SIOUX CITY, IA 51106

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W 368	Continued From page 11 grabbed med bin and began putting out medications for Client #15. Client #15 set up his medications in a plastic cup and walked out of the medication room before taking them." RN A further noted he went to get Client #15 to finish medication administration when Client #14 approached the med room. He then asked Client #14 if he wanted to take his medications. Client #14 entered the med room and RN A began to prepare Client #14's MiraLax/Lactulose drink. As he did this Client #14 took Client #15's meds from the counter and swallowed them. Continued record review revealed a 1/1/20 Interdisciplinary Progress Note written by RN B which noted the Physician had been called due to Client #14 being unbalanced in his chair, slumped down and unable to remain upright. Client #14 then became unresponsive and 911 was called. According to Client #14's Physicians Form, Client #14's current a.m. medications included: Senna-S Tablet, Divalproex Tab 500 Mg Dr, Levothyroxine Tab 137 Mcg, Risperidone Tab .25 Mg, Selenium Sul Sha 2.5%, Therems-M tab, Dilantin Cap 30 mg, Metoprolol tab 100 Mg ER, Sertraline Tab 100 Mg, Chlorex Glu Sol .12%, Phenytoin Er Cap 100 mg, Ammonium Lac lot 12%, Calcium Carb-D, Constulose Sol 10 Gm/15ml, Nystatin Pow 100000, Polyeth Glycol 3350 Pow, Retin-A Cre 0.05%. According to Client #15's Physicians Form, Client #15's current a.m. medications included: Bupropion Hcl xl 150 Mg Tab, Ferrous Sulfate Tab 325 Mg, Fluoxetine Cap 20 mg, Folic Acis 1 Mg Tab, Multivitamin Tab, Clozapine 25 Mg Tablet, Clozapine 100 Mg Tablet, Debrox Sol 6.5% OT, Primadone Tab 50 Mg.	W 368		

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 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HOMES	2815 LINCOLN WAY SIOUX CITY, IA 51106

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W 368	Continued From page 12 Continued record review on 1/6/20 revealed Client #14's after visit summary from his Unity Point Emergency Revisit dated 1/1/20. The Summary indicated Client #14, a 52 year old male, accidentally received another resident's medication. The medication included folic acid, multivitamin, Primidone, Clozapine, Iron, Prozac and Wellbutrin. The patient was normally fully awake but appeared very sleepy. He had yet to receive his normal medications. Staff denied any fall/injury or vomiting. Vitals read: temperature, 98.4 F; heart rate 70; blood pressure 132/83. Upon arrival at the emergency room Client #14 was not in respiratory distress. His heart rate was normal and he was not in distress. The Client became more responsive at the emergency room and was eventually discharged at 6:16 p.m. Further review on 1/6/19 at 3:00 p.m. revealed RN A trained on the facility policy for medication administration. The medication policy directed the following: Have available the Medication Administration Record (MAR) for the consumer and the consumer's medication. The MAR and medication should be compared to insure that they are the same. Continued review revealed RN A had also been trained on the six rights of medication administration: right person, medication, dose, route, time and documentation. When interviewed on 1/7/20 at 8:15 a.m. RN A stated he did not use the (MAR) during medication administration with Client #14. He stated he turned around setting up the liquid medication for Client #14 and when he turned	W 368		

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 01/09/2020

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 368	Continued From page 13 around Client #14 took medication in a plastic cup on the counter that belonged to Client #15. At the time he didn't realize Client #14 had just taken the medications he previously set up for Client #15. RN A stated approximately 15-25 minutes later Client #15 returned to the med room and asked for his meds he set up just prior. He stated at this time he realized Client #14 probably received Client #15's medications. He admitted he gave the wrong medication to Client #14. He confirmed he failed to administer medications according to physician orders and follow policy and procedure. He admitted he "made a mistake."	W 368		

dlc 3/12/20

✓ 3/12/20

Park View Homes 2020 Plan of Correction

W104 A check off sheet was developed to track observations of med passes by Nursing staff to ensure proper med pass protocol. The Director of Nursing will continue to complete observations of med passes by Nursing staff. These check-off sheets will be turned in weekly to the Administrator.

Responsible: Administrator, Director of Nursing
Frequency: Continual
Completion Date-2/18/2020

W234 Member's programs will be reviewed and revised to clearly define necessary information in order to ensure staff are consistently implementing programs as written. Member programs will be reviewed and revised at bi-weekly staff meetings.

Responsible: QIDP
Frequency: Continual
Completion Date-4/7/2020

W339 Pharmacy/Physician recommendations will be reviewed by the Director of Nursing/nursing staff and implemented as written. Recommendations will be reviewed with nursing staff at meetings. Check sheets with side effects will be provided, reviewed by the D.O.N. and turned into the Administrator for review each month.

Responsible: Director of Nursing, Administrator
Frequency: Continual
Completion Date-4/7/2020

W368 Nurses and Certified Med-Aides have been re-trained in med pass protocol procedures. The 6 rights of med passing were reviewed at nurses' meeting. The 6 rights of med passing have been posted in the med rooms as a reminder to follow the proper med pass protocol.
A check off sheet was developed to track observations of med passes by Nursing staff to ensure proper med pass protocol.
The Director of Nursing will continue to complete observations of med passes by Nursing staff. These check-off sheets will be turned in weekly to the Administrator.

Responsible: Director of Nursing, Administer
Frequency: Continual
Completion Date-2/18/2020

Leslie Ritchie, Administrator
Leslie Ritchie
Park View Homes