

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: 6813		Date: June 12, 2018		
Facility Name: Neuro Restorative IA City		Survey Dates: May 7-9, 2018		
Facility Address/City/State/Zip 4569 Jenn Lane				
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

56.6(1)	<p>481—56.6(135C) Treble and double fines. 56.6(1) Treble fines for repeated violations. The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor. (cited during December 14, 2017 investigation)</p> <p>481—56.12(135C) Class I violation as a result of multiple lesser violations. The director of the department of inspections and appeals may issue a citation for a class I violation when a physical condition or one or more practices exist in a facility which are a result of multiple lesser violations of the statutes or rules, but which taken as a whole constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.</p>	I	\$12,000 (treble)	UPON RECEIPT
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Facility Administrator

Date

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<p>481-63.23(135C) Safety. The licensee of a residential care facility for the intellectually disabled shall be responsible for the provision and maintenance of a safe environment for residents and personnel.</p> <p>63.23(3) Resident safety. e. Residents shall receive adequate supervision to ensure against hazards from themselves, others, or elements in the environment.</p> <p>481—63.8(135C) Administrator. Each residential care facility for the intellectually disabled shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. (III)</p> <p>63.8(7) The administrator shall: a. Be responsible for the selection and direction of competent personnel to provide services for the resident care program; (III)</p> <p>DESCRIPTION:</p>				
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	<p>Based on interview and record review, the facility failed to provide adequate supervision and competent personnel to provide services for resident care programs for 2 of 4 residents reviewed (Resident #1 & #4). Resident # 4 was also cited in a citation issued December 14, 2017 for elopements.</p> <p>Findings include:</p> <p>1. Record review for Resident #1 revealed an Individual Daily Activity Plan (IDAP) dated 3/18/18. The IDAP indicated the facility received a call on that date from Resident #1's sister at 3:34 PM informing staff she had been called by her brother (Resident #1). The sister informed staff Resident #1 walked to the store and got lost on the way back to the facility. When located the resident reported feeling anxious about being on the road alone. Staff documented Resident #1 smelled of alcohol.</p> <p>Interviews with Staff B on 5/8/18 at 11:58 AM and Staff E on 5/8/18 at 2:10 PM revealed Resident #1 was placed on 15 minutes checks following the elopement on 3/18/18.</p>			
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	<p>Review of an Incident Report dated 4/5/18 revealed Resident #1 eloped on that date with Resident #4. The incident report indicated when staff went to check on Resident #1 at 2:30 PM, he could not be located. Staff went to look for Resident #1 in the community.</p> <p>An IDAP dated 4/5/18 documented the resident was found hiding behind a gas station at 3:40 PM. Resident #1 reported drinking a few beers.</p> <p>A review of a Participant Frequent Check Form dated 4/5/18 revealed Resident #1 was checked on every 15 minutes that day up to 2:00 PM. Resident #1 was not checked on at 2:15 PM.</p> <p>According to Resident #1's record, he was admitted to the facility on 11/2/17 with diagnoses including brain injury (secondary to stroke), anxiety disorder, and a history of heroin and alcohol abuse. The background information included in his/her most recent</p>			
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	<p>ISP dated 5/1/2018 indicated the resident had issues with impaired cognition, poor reasoning and problem solving, and depression with anxiety. The resident required 24 hour supervision. The resident had a BSP for elopement. The BSP was revised on 3/28/18 to update the level of supervision to state the resident did not need constant visual supervision when outside his/her bedroom, but did require constant visual supervision when outside the house for any reason to ensure whereabouts to prevent elopement. There was no other indication in either the ISP or BSP regarding level of supervision when not outside.</p> <p>2. A review of an Incident Report dated 3/18/18 revealed Resident #4 eloped from the facility on that date. An IDAP dated 3/18/18 revealed Resident #4 was found walking up the driveway with a bag of food from Subway at 3:36 PM.</p> <p>A review of a Participant Frequent Check</p>			
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	<p>Form dated 3/18/18 revealed Resident #4 was on 30 minute checks the day of the elopement. The form indicated Resident #4 was last checked on at 3:00 PM. According to Google Maps, the Subway restaurant to which Resident #4 walked was located 1.7 miles from the facility.</p> <p>Google maps indicated the time it would take a person to make a round trip walk was 70 minutes. Record review revealed the staff who worked at that time received disciplinary action.</p> <p>Interviews with Staff B on 5/8/18 at 11:58 AM and Staff E on 5/8/18 at 2:10 PM revealed Resident #4 was placed on 15 minutes checks following the elopement on 3/18/18.</p> <p>A review of an incident report dated 4/5/18 revealed Resident #4 eloped with Resident #1 on that date. Staff realized Resident #4 was missing at 2:30 PM. Staff searched by car and found the resident hiding behind a gas station.</p> <p>A review of a Participant Frequent Check</p>			
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	<p>Form dated 4/5/18 revealed the resident had been checked on every 15 minutes that day until 2:00 PM. Resident #4 was not checked on at 2:15 PM. According to the Participant Frequent Check Form, Resident #4 returned to the facility at 4:00 PM.</p> <p>According to Resident #4's record, he was admitted to the facility on 6/16/17 with a diagnosis of traumatic brain injury (secondary to stroke) and Moya-Moya disease (blood vessel disorder). The background information included in his most recent ISP dated 5/1/2018 indicated the resident had issues with impaired cognition, poor reasoning and problem solving, and depression with anxiety. The resident required 24 hour supervision. The resident had a BSP for elopement. The BSP was revised on 3/28/18 to update the level of supervision to state the resident did not need constant visual supervision when outside his bedroom, but did require constant visual supervision when outside the house. There was no other indication in either the ISP or BSP regarding level of supervision when not outside.</p>			
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	<p>3. During an interview with the Administrator on 5/7/18, she confirmed Resident #1 and Resident #4 have been on 15 minute checks since the elopements on 3/18/18. She reported this requirement was not documented in either resident's service plan. Fifteen minute checks were routinely completed on 4 of the 5 residents of the house.</p> <p>On 5/9/18 at 2:30 PM, the Administrator acknowledged staff did not supervise Residents #1 and #4 as required on 4/15/18 (15 minute checks). Resident #4 was not supervised as needed on 3/18/18 (30 minute checks). She stated no adjustments were made to the supervision level or service plan following the elopements on 4/15/18 but staff were reeducated on supervision expectations.</p> <p>In order to walk to BP gas station Residents #1 and #4 walked along Highway 1 which is a busy two lane with a speed limit of 55 miles per hour. For the entire route to gas station there are no sidewalks along the entire route. The shoulder along Highway 1 was</p>			
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	<p>only few feet wide.</p> <p>FACILITY RESPONSE:</p>			
50.7	<p>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.</p> <p>DESCRIPTION:</p> <p>Based on interview and record review the facility failed to notify the Department within 24 hours or the next business day regarding elopements by 2 of 4 residents reviewed (Residents #1, #4).</p> <p>Findings follow:</p> <p>Review of an Individual Daily Activity Plan (IDAP) dated 3/18/18 regarding Resident #1 revealed the resident's sister called the facility</p>	II	\$500 (treble)	UPON RECEIPT

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	<p>at 3:34 PM to report her sibling had called saying he had gone to the store but got lost trying to get back home. Staff gathered the other residents and went to look for Resident #1. The resident was located standing by a road. Staff noted Resident #1 smelled like beer.</p> <p>Review of an IDAP dated 3/18/18 regarding Resident #4 revealed the resident was seen at 3:36 PM walking in the driveway with a Subway bag in his/her hands. The resident stated he left the facility to get a sub.</p> <p>An interview with the Administrator on 5/8/18 at 11:40 revealed Resident #1 and Resident #4 walked to a gas station without staff knowledge on 3/18/18. The Administrator confirmed the incident on 3/18/18 was an elopement and it was not reported to the Department.</p>			
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