

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

Citation Number: <b>5382</b>		Date: <b>September 21, 2021</b>		
Facility Name: <b>Pride Group at Lincoln St.</b>		Survey Dates: <b>August 2, - 5, 2021</b>		
Facility Address/City/State/Zip <b>1240 Lincoln Street Le Mars, Iowa 51031</b>		LK	#98853-I	
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

<b>57.34(3)c</b>	<p><b>481-57.34(135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II, III)</b></p> <p><b>57.34(3) Resident safety.</b></p> <p><b>c. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (I, II, III)</b></p> <p>Based on interview and record review the facility failed to provide proper supervision to 2 of 3 residents reviewed regarding Incident #98853-I (Resident #1 and Resident #2). Findings follow:</p> <p>Record review on 8/2/21 revealed an incident report for Resident #3 dated 7/26/21. Resident #3 became angry on that date and charged at the Administrator's door, attempting to enter the office. He was unable to do so. Resident #3 saw the Resident Service Coordinator in the hallway who asked if he was okay. He then started running toward her. At that time, residents and staff were alerted via the loudspeaker to stay upstairs or behind a locked door and the police were called. Resident #3 punched the glass on a</p>	<b>I</b>	<b>\$2,500.00</b>	<b>Upon Receipt</b>
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Facility Administrator

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Date

**If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).**

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	<p>fire door and broke the window. He started cutting on his arm and hand with the glass. He then punched the glass out of the front door and a larger piece of glass broke out. Resident #3 took the larger piece of glass out and cut his throat on one side of his body. Resident #3 continued to cut his throat in different areas while also using his head to try and enter the break room where the Dietary Manager was located.</p> <p>The Assistant Director of Nursing (ADON) reported on 8/3/21 at 9:30 AM she started getting residents into their rooms on the second floor as soon as she was notified by the Director of Nursing to do so. She did this with the assistance of the Certified Medication Assistant (CMA). Once all residents were in their rooms (she was not sure they were behind locked doors), she went to the nurse's station with the CMA and housekeeper and locked the door behind them. The ADON recalled seeing Resident #2 on the video cameras on the first floor where Resident #3 was located. She did not see Resident #1 on the camera.</p> <p>On 8/3/21 at 7:50 AM, the Dietary Manager reported she observed Resident #1 and Resident #2 in the hallway by Resident #3 on 7/26/21. Resident #3 was holding a piece of glass to his</p>			
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	<p>neck and Resident #2 was asking Resident #3 if he was okay. The Dietary Manager asked Resident #1 and Resident #2 to go outside for their safety but was then directed to go back in the break room by the Resident Service Coordinator. The Dietary Manager was not sure if the residents went outside. The Dietary Manager expressed fear Resident #3 would get through the break room door when he was hitting it with his head and fists.</p> <p>On 8/2/21 at 4:10 PM, Resident #2 reported she came down from the second floor when she heard the loud banging. Resident #2 could hear an announcement but didn't understand what was said. When she got to the first floor, she saw Resident #3 break the glass and jam a piece of it into his throat twice. She stayed with him until the police arrived. Resident #2 said no staff approached her or asked her to walk away from Resident #3.</p> <p>On 8/3/21 at 10:05 AM, Resident #1 reported she was sleeping and did not hear an announcement to remain upstairs. She was awakened by a loud banging. Resident #1 went downstairs and did not encounter any staff on her route. When she got there, she saw Resident #3 with a piece of glass in his hand. He stuck it in his neck one time.</p>			
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	<p>Resident #1 then left the area but was not asked to do so by staff.</p> <p>On 8/3/21 at 10:40 AM the Administrator reported she was aware Resident #2 was on the first floor during the incident but not Resident #1. She was unaware of this until hearing it from the Dietary Manager on 8/3/21. The Administrator believed Resident #3 was targeting staff members, not residents on 7/26/21.</p> <p><b>FACILITY RESPONSE</b></p>			
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