DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	170501	A. BUILDING: _____ B. WING _____	05/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH IOWA TRANSITION CENTER	408 FIRST STREET NW MASON CITY, IA 50401

(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) COMPLETE DATE
C 000	Initial Comments The following deficiencies were cited during the survey conducted to determine compliance with licensing rules for a Residential Care Facility for Persons with Mental Illness.	C 000		
C 147	50.7(4) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report an elopement to the Department within 24 hours or the next business day as required for 1 of 3 residents reviewed (Resident #3). Findings include: A review of incident reports on 5/15/18 revealed Resident #3 left the facility on 4/6/18 without telling staff or signing out in the log book. The resident left the premises to walk to the hospital several blocks away to be evaluated. The resident was admitted for a mental health evaluation and discharged back to the facility on 4/9/18. Further review revealed the facility did not report the elopement to the Department. Resident # 3's diagnoses included schizoaffective disorder, a history of alcohol	C 147	Plan of Correction is attached 6/22/18	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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C 147	Continued From page 1 abuse and seizure disorder. An interview with the Administrator on 5/15/18 at 2:00 p.m. confirmed this finding.	C 147		
I 168	62.8(1)b Administration 481-62.8(135C) Administration. 62.8(1) The licensee shall: b. Be responsible for compliance with all applicable laws and with the rules of the department. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to comply with requirements related to notifications to the Department found in Iowa Administrative Code 481-chapter 50. Findings include: A review of incident reports revealed the facility failed to notify the Department of an elopement as required by Iowa Administrative Code rule 50.7(4). The administrator confirmed this finding. See deficiency under 50.7(4) for details.	I 168		
I 174	62.9(1)b Personnel 481-62.9(135C) Personnell 62.9(1) The personnel policies and procedures shall include the following requirements: b. Annual performance evaluation of all	I 174		

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I 174	Continued From page 2 employees and consultants which is dated and signed by the employee or consultant and the supervisor. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure annual evaluations were competed annually for 2 of 2 staff reviewed employed over a year (the Administrator and Staff F). Findings include: A review of the Administrator's personnel file revealed a hire date of 11/3/14. The Administrator's record revealed the last annual performance evaluation was in 2015. No performance evaluation was completed in 2016 or 2017. A review of Staff F's personnel file revealed a hire date of 12/27/16. Staff F's record revealed the last annual performance evaluation was in March of 2017. No performance evaluation was completed in March of 2018. On 5/15/18 at 10:45 AM, the Administrator confirmed the finding.	I 174		
I 245	62.11(5) Evaluation services 481--62.11(135C) Evaluation services. 62.11(5) A narrative social history shall be completed for each resident within 30 days of admission and approved by the qualified mental health professional prior to the development of the IPP.	I 245		

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I 245	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record reviews and interview the facility failed to ensure social histories were completed and approved by a qualified mental health professional (QMHP) within 30 days after admission for 2 of 3 residents reviewed (Resident #1 and Resident #3). Findings include: A review of Resident #1's record revealed an admission date of 12/11/17. A social history was completed on the day of admission by a staff member. There was no indication the social history had been reviewed or approved by a QMHP. A review of Resident #3's record revealed an admission date of 1/16/18. A social history was completed 7/29/17 by a staff member during a previous admission. There was no indication the social history had been reviewed or approved by a QMHP. In addition, no updated social history completed within 30 days of admission in January could be located. On 5:15 PM at 2:15 PM, the Administrator confirmed these findings.	I 245		

✓ 6/25/18

DATE: **June 11, 2018**

To: **Iowa Department of Inspections and Appeals**

From: **North Iowa Transition Center, Inc.**
Provider ID 170501
408 First Street NW
Mason city, IA 50401

RE: **Corrective Action Plan for Survey completed 5/16/18**

DEFICIENCIES	PLAN OF ACTION OF CORRECTION
C 147 50.7(4) Additional Notification. The director or directors designee shall be notified within 24 hours, or the next business day, by the most expeditious means available.	NITC policies and procedures for reporting incidents were reviewed by management and determined to include the appropriate criteria and timelines. Leadership has conducted additional education and training of personnel to ensure that incidents are correctly identified and reported in a timely manner. Completed 5/23/18. In addition, the Quality Improvement team will annually conduct a written analysis of all critical incidents to address causes, trends, actions for improvement, prevention of recurrence, staff training needs and internal/external reporting requirements. Completion date 7/15/18.
I 168 62.8(1)b Administration 481-62.8(135C) Administration 62.8(1) The licensee shall: b. be responsible for compliance will all applicable laws and with the rules of the department.	
I 174 62.9(1)b Personnel 481-62.9(135C) Personnel 62.9(1) The personnel policies and procedures shall include the following requirements: b. Annual performance evaluation of all employees and consultants which is dated and signed by the employee or consultant and the supervisor.	The Human Resource Assistant will conduct a review of personnel files by 6/15/18 to ensure that all personnel have received an annual performance review. Management will complete all outdated performance reviews, including the RCF Administrator, by 7/1/18.
I 245 62.11(5) Evaluation Services. **481-62.11(135C) Evaluation Services** **62.11(5)** A narrative social history shall be completed for each resident within 30 days of admission and approved by the qualified mental health professional prior to the development of the IPP.	It is the policy of NITC to complete all social histories within 30 days after admission with approval from the QMHP. A record review was completed by 6/1/18 to ensure that all files include current social histories that are completed in a timely manner and approved by the QMHP.

DD — 6/22/18