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
	520023	A. BUILDING: _____ B. WING _____	C 05/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEURORESTORATIVE - IOWA CITY	4569 JENN LANE IOWA CITY, IA 52240

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C 000	Initial Comments The following deficiencies were cited during investigation 75090-I as well as the survey conducted to determine compliance with regulations for a 3 to 5 bed specialized license.	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 notify the Department within 24 hours or the next business day regarding elopements by 2 of 4 residents reviewed (Residents #1, #4). Findings follow: Review of an Individual Daily Activity Plan (IDAP) dated 3/18/18 regarding Resident #1 revealed the resident's sister called the facility at 3:34 PM to report her sibling had called saying he/she 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. Review of an IDAP dated 3/18/18 regarding	C 147	Plan of Correction is attached DD 7/14/18	

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 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/she left the facility to get a sub. 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.	C 147		
S 129	59.8(2) Baseline TB screening for residents 481-59.8(135B,135C) Baseline TB screening procedures for residents of health care facilities. 59.8(2) All residents shall be assessed for current symptoms of active TB disease upon admission. Within 72 hours of a resident's admission, baseline TB testing for infection shall be initiated unless baseline TB testing occurred within three months prior to the resident's admission. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to complete baseline TB testing for 1 of 2 residents reviewed who were admitted since December 2017 (Resident #2). Baseline TB screening consists of two components: (1) assessing for current symptoms of active TB disease and (2) using two-step TST or a single IGRA to test for infection with M. tuberculosis. Findings include:	S 129		

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S 129	Continued From page 2 A review of Resident #2's file revealed an admission date of 12/27/17. No TB testing could be located for Resident #2. On 5/8/18 at 11:40 AM the Administrator confirmed no TB testing was completed for Resident #2.	S 129		
M 201	63.8(6)b Administrator 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. 63.8(6) 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. In addition the facility failed to ensure 4 of 5 staff reviewed had completed training regarding the identification and reporting of dependent adult abuse as required by Chapter 235B (Staff B, C, D, F). Findings include: 1. A review of facility records revealed the facility failed to notify the Department of elopements as required by Iowa Administrative Code rule 50.7(4). Interview with the Administrator confirmed this finding. See deficiency under	M 201		

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M 201	Continued From page 3 50.7(4) for details. 2. Chapter 235 B requires that employees complete two hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment and at least two hours of additional dependent adult abuse identification and reporting training every five years using an approved curriculum. Review of Staff B's file revealed a hire date of 1/26/17. There was no documentation of completion of a Dependent Adult Abuse training course in Staff B's personnel file. Review of Staff C's file revealed a hire date of 11/7/14. There was no documentation of completion of a Dependent Adult Abuse training course in Staff C's personnel file. Review of Staff D's file revealed a hire date of 10/31/14. There was no documentation of completion of a Dependent Adult Abuse training course in Staff D's personnel file. Review of Staff F's file revealed a hire date of 3/2/15. There was no documentation of completion of a Dependent Adult Abuse training course in Staff F's personnel file. The Administrator confirmed these findings on 5/9/18 at 1:40 PM.	M 201		
M 204	63.8(7)a Administrator 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	M 204		

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M 204	Continued From page 4 accordance with these regulations. 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; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure competent personnel provided services for resident care programs for 2 of 4 residents reviewed (Resident #1 & #4). Residents #1 and #4 were not receiving the required 30 minute checks and 15 minute checks according to their behavioral service plan. Both residents left facility grounds without staff knowledge as the checks were not completed. Findings include: 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. 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	M 204		

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M 204	Continued From page 5 #1 was placed on 15 minutes checks following the elopement on 3/18/18. 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. 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. The BSP was revised on 3/28/18 to update the level of supervision Resident #1 required. The BSP indicated the resident did not need constant visual supervision when outside his 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. 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. A review of a Participant Frequent Check 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.	M 204		

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M 204	Continued From page 6 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. 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. 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. A review of a Participant Frequent Check 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. 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. 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	M 204		

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M 204	Continued From page 7 were routinely completed on 4 of the 5 residents of the house. 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.	M 204		
M 206	63.8(7)c Administrator 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. 63.8(7) The administrator shall: c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure monthly in-service programs were conducted. Findings follow: A review of facility training records revealed no documentation of monthly in-service educational	M 206		

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M 206	Continued From page 8 programs being held for employees for the months of April 2016 through December 2017. The Administrator confirmed these findings during an interview on 5/8/18 at 1:25 PM.	M 206		
M 314	63.15(7) Physical examinations 481--63.15(135C) Physical examinations. 63.15(7) Residents shall be admitted to a residential care facility for the intellectually disabled only on a written order signed by a physician certifying that the individual being admitted requires no more than personal care and supervision but does not require nursing care. This rule is intended to implement Iowa Code sections 135C.23(2). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to obtain a written order stating the individual required no more than personal care and supervision but did not require nursing care for 1 of of 4 residents reviewed (Resident #2 Findings follow: Review of Resident #2's file revealed an admission date of 12/27/17. No order regarding the resident's level of care could be located. When interviewed on 5/8/18 at 11:40 AM, the	M 314		

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M 314	Continued From page 9 Administrator confirmed the facility did not have a level of care order for Resident #2.	M 314		
M 333	63.17(1)l Records 481--63.17(135C) Records. 63.17(1) Resident records. The licensee shall keep a permanent record on all residents admitted to a residential care facility for the intellectually disabled with all entries current, dated, and signed. The record shall include: l. Physician's orders for medication, treatment, and diet in writing and signed by the physician; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to obtain written diet orders for 4 of 4 residents reviewed (Residents #1, #2, #3, #4). Findings follow: Record review revealed Resident #1 was admitted to the facility on 11/2/17. A review of physician's orders revealed no written order addressing Resident #1's diet. Record review revealed Resident #2 was admitted to the facility on 12/27/17. Discharge recommendations written by a Registered Nurse from Resident #2's previous placement stated the resident "can eat a regular diet, thin liquids. Solids chopped in bited sized pieces." A review	M 333		

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M 333	Continued From page 10 of physician's orders revealed no written order addressing Resident #2's diet. Record rview revealed Resident #3 was admitted to the facility on 3/16/18. A review of physician's orders revealed no written order addressing Resident #3's diet. Record review revealed Resident #4 was admitted to the facility on 6/16/17. A review of physician's orders revealed no written order addressing Resident #4's diet. The Administrator confirmed the facility did not have diet orders for these residents during an interview on 5/8/18 at 2:40 PM.	M 333		
M 339	63.17(1)r Records 481--63.17(135C) Records. 63.17(1) Resident records. The licensee shall keep a permanent record on all residents admitted to a residential care facility for the intellectually disabled with all entries current, dated, and signed. The record shall include: r. A notation describing condition on admission, transfer, and discharge; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to document condition on discharge for 2 of 4 former residents reviewed (Residents C-1, C-3). Findings follow: Record review revealed Resident C-1 was	M 339		

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M 339	Continued From page 11 discharged from the facility on 10/20/17. The facility did not document Resident C-1's condition at the time of discharge. Record review revealed Resident C-3 was discharged from the facility on 6/22/16. The facility did not document Resident C-3's condition at the time of discharge. An interview with the Administrator on 5/8/18 at 4:00 PM confirmed these findings.	M 339		
M 372	63.18(1)b(11) Drugs 481--63.18(135C) Drugs. 63.18(1) Drug storage. b. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements: (11) Inspection of drug storage condition shall be made by the administrator and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician's order, and drugs improperly stored. This REQUIREMENT is not met as evidenced	M 372		

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M 372	Continued From page 12 by: Based on interview and record review the facility failed to maintain signed copies of inspections of stored medications. Findings follow: The Administrator stated in an intervew on 5/8/18 at 4:00 the facility did not maintain copies of the inspections of stored medication. The pharmacy was able to fax this information to the Administrator. A review of the faxed material revealed the former Administrator had not verified the reports with his signature. The Administrator confirmed the inspection reports were not signed by the former administrator.	M 372		
M 378	63.18(2)d Drugs 481--63.18(135C) Drugs. 63.18(2) Drug safeguards. d. When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure physician orders were obtained to send medications for 2 of 4 former residents reviewed (Residents C-1, C-3). Findings follow: Record review revealed Resident C-1 was discharged from the facility on 10/20/17. A review of the facility's discharge record showed	M 378		

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M 378	Continued From page 13 bottles of 22 medications were sent with the resident at the time of discharge. No written order was received from a physician prior to releasing the medication to Resident C-1. Record review revealed Resident C-3 was discharged from the facility on 6/22/16. A review of the facility's discharge record showed bottles of 7 medications were sent with the resident at the time of discharge. No written order was received from a physician prior to releasing the medication to Resident C-3. The Administrator confirmed these findings on 5/8/18 at 4:00 PM and reported being unaware of this requirement. On 5/8/18 at 4:00 PM the Administrator confirmed this finding and stated she was unaware physician orders had to be obtained to send meds with discharging residents.	M 378		
M 519	63.23(3)e Safety 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. 63.23(3) Resident safety. e. Residents shall receive adequate supervision to ensure against hazards from themselves, others, or elements in the environment.	M 519		

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M 519	Continued From page 14 This REQUIREMENT is not met as evidenced by: 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. Findings include: 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. 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. 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. 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.	M 519		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520023	A. BUILDING: _____ B. WING _____	C 05/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 519	Continued From page 15 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. 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 An Individual Service Plan (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. 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. A review of a Participant Frequent Check 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	M 519		

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M 519	Continued From page 16 Subway restaurant to which Resident #4 walked was located 1.7 miles from the facility. 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. 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. 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. A review of a Participant Frequent Check 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. 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	M 519		

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M 519	Continued From page 17 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. 3. 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 the gas station on Highway 1 there are no sidewalks. The shoulder along Highway 1 was only few feet wide. 4. 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. 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.	M 519		
M 817	63.47(14)b Specialized License for 3-5 bed facilities 63.47(14) Goals and objectives shall be stated separately and a time frame shall be specified for their achievement. (II, III)	M 817		

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
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M 817	Continued From page 18 b. The initial individual program plan shall be developed within 30 calendar days after the individual is enrolled in this service. (II) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure service plans were developed within 30 days for 1 of 4 residents reviewed (Resident #3). Findings follow: Review of Resident #3's file revealed an admission date of 3/16/18. Resident #3 lived in another facility run by the agency prior to moving to this facility. The service plan located in the file, dated 2/20/18, was developed while a resident at the former facility. The goals on the service plan expired on 6/30/18. A new service plan was not written when Resident #3 moved to the current residence. During an interview with the Administrator on 5/7/18 at 11:30 AM, she confirmed a new service plan was not created for Resident #3. The Administrator considered Resident #3's move a transfer rather than a new admit and believed a new service plan was not necessary as the goals from the other facility had not expired or been achieved.	M 817		
M309A	481--63.15(2)c Physical Examinations 481--63.15(135C) Physical examinations. 63.15(2) Each resident admitted to a residential care facility for the intellectually disabled shall have had a physical examination prior to	M309A		

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
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M309A	Continued From page 19 admission. c. Screening and testing for tuberculosis shall be conducted pursuant to 481--Chapter 59. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to comply with requirements related to tuberculosis testing found in Iowa Administrative Code - Chapter 59. Findings include: A review of resident files revealed the facility failed to complete TB screenings as required by Iowa Administrative Code rule 481-59.8 (2) for 1 of 2 residents reviewed admitted since 12/27/17 (Resident #2). See deficiency under 59.8 (2).	M309A		

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7/18/18

Plan of Correction

Deficiency Cited: 50.74 (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 sub rule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff.

Corrective Action Plan:
Going forward we will comply with code 63.23 e, ensuring that in the event of a resident eloping from the facility that the director or director's designee will be notified within 24 hours, or the next business day, by the most expeditious means available. The program director will provide oversight to ensure this is completed within the identified time frame.

Deficiency Cited: 59.8 (2) Baseline TB screening for residents
59.8 (2) All residents shall be assessed for current symptoms of active TB disease upon admission. Within 72 hours of a residents admission, baseline TB testing for infection shall be initiated unless baseline TB testing occurred within three months prior to the residents admission.

Corrective Action Plan:
Going forward we will comply with code 59.8 (2), ensuring all residents be assessed for current symptoms of active TB disease upon admission. Going forward the Administrator will work closely with the Clinical Evaluator to ensure TB tests are conducted prior to admission and if not that baseline testing is initiated within 72 hours of the clients admission to the program.

Deficiency Cited: 63.8 (6) b Administrator
63.8 (6) The licensee shall: (b) responsible for compliance with all applicable laws and with the rules of the department.

Corrective Action Plan:
Going forward we will comply with code 63.8(6), ensuring the director or directors designee be notified within 24 hours or next business day by the most expeditious means available. The program director will provide oversight to ensure this is completed within the identified time frame.

Deficiency Cited: 63.8 (7) Administrator
63.8 (7) The administrator will be responsible for the selection and direction of competent personnel to provide services for the resident care program.

Corrective Action Plan:
Going forward we will comply with code 63.8(7), ensuring the administrator follows the hiring process designed and providing continued oversight, re-training and disciplinary action as needed to ensure we maintain competent personnel. The Administrator will work closely with the Behavioral Analyst to provide a thorough review of each resident's service plan and behavioral support plan to all employees to ensure they are understood and consistently implemented. The Administrator will closely monitor the day to day activities conducting observations to ensure employees are following the support plans as written and providing feedback and additional training as needed to ensure employees are providing the services outlined. The administrator will also follow our progressive disciplinary action process that includes up to termination.

Deficiency Cited: 63.8 (7) Administrator
63.8 (7) The administrator shall: (c) be responsible for conducting monthly in-service educational programs for all employees and to maintain records of programs and participants.

Corrective Action Plan:

7/16/18

Going forward we will comply with code 63.8 (7), ensuring that monthly in-services educational programs for all employees are conducted and filed in a location accessible at all times. The program director will provide onsite reviews to ensure these monthly meetings are being conducted and records are present indicating these.

Deficiency Cited: 63.15 (7) Physical Examinations

63.15 (7) Residents shall be admitted to a residential care facility for the intellectually disabled only on a written order signed by a physician certifying that the individual being admitted requires no more than personal care and supervision but does not require nursing care.

Corrective Action Plan:

Going forward we will comply with code 63.15 (7), ensuring that we obtain a written order signed by a physician certifying that the individual being admitted requires no more than personal cares and supervision but does not require nursing care prior to admission. Going forward the Administrator will work closely with the Clinical Evaluator to ensure we obtain signed orders prior to admission.

Deficiency Cited: 63.17 (1) Records

63.17 (1) Resident Records. The licensee shall keep a permanent record on all residents admitted to a residential care facility for the intellectually disabled with all entries current, dated and signed. The record shall include: l. Physician orders for medication, treatment, and diet in writing and signed by the physician.

Corrective Action Plan:

Going forward we will comply with code 63.17, ensuring that all admitted residents have signed physician orders for medication, treatment and diets. Going forward the Administrator will work closely with the Clinical Evaluator to ensure we obtain signed physician orders prior to admission.

Deficiency Cited: 63.17 (1) Records

63.17 (1) Resident Records. The licensee shall keep a permanent record on all residents admitted to a residential care facility for the intellectually disabled with all entries current, dated and signed. The record shall include: r. A notation describing condition on admission, transfer and discharge.

Corrective Action Plan:

Going forward we will comply with code 63.17, ensuring that any resident upon admission, transfer or discharge have a notation in their file indicating their condition prior to those events. The program director will provide oversight to ensure the admission and/or discharge packet is thoroughly being completed throughout the discharge process to include indicating the clients condition prior to an admission or discharge.

Deficiency Cited: 63.18 (1) Drug Storage

63.18 (1) b. Drug Storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:
(11) Inspection of drug storage condition shall be made by the administrator and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician's order, and drugs improperly stored.

Corrective Action Plan:

Going forward we will comply with code 63.18 (1) b ensuring that all inspection copies are signed by the administrator and a copy is maintained on site. The program director will provide onsite reviews to ensure these quarterly inspections are being conducted and records are present and signed.

Deficiency Cited: 63.18 (2) d Drugs

63.18 (2) d. When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician.

Corrective Action Plan:

Going forward we will comply with code 63.18 (2) d and ensure that a written order from a physician is obtained prior to unused prescriptions being sent with a discharging resident. The program director will provide oversight to the Administrator throughout the discharge process to ensure written orders by a physician are obtained if prescriptions are to be sent with the client discharging.

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Deficiency Cited: 63.23 (3) e Safety
63.23(3) e Safety. Residents shall receive adequate supervision to ensure against hazards from themselves, others, or elements in the environment.

Corrective Action Plan:
Going forward we will comply with code 63.23, ensuring that all residents receive adequate supervision to ensure against hazards from themselves, others or elements in the environment. The Administrator and the Behavioral Analyst will hold a staff meeting to provide a thorough review of each resident's service plan and behavioral support plan to all employees to ensure they are understood and consistently implemented to ensure client safety. The Administrator and Behavioral Analyst will also continue to follow up on implementation by reviewing service plans and behavioral support plans at each monthly staff meeting. In addition the program will install door alarms to alert staff when a resident may attempt to exit out a back or side door. The program will also relocate the area in which employees complete their documentation to provide more visibility within main area of the home to promote additional supervision. The program will also increase staffing ratios to provide additional supervision within the home during times of resident appointments or outings. In addition we will continue to encourage residents with histories of substance abuse or seeking substances to engage in a local treatment program within the community with our support. The program will also further discuss potential discharge options for clients who are their own person and are seeking to have unsupervised time.

Deficiency Cited: 63.47 (14) b Specialized License for 3-5 bed facilities
63.47 (14) b Specialized License for 3-5 bed facilities. Goals and objectives shall be stated separately and a time frame shall be specified for their achievement. (b) The initial individual program plan shall be developed within 30 calendar days after the individual is enrolled in this service.

Corrective Action Plan:
Going forward we will comply with code 63.47 (14) b ensuring an initial individual program plan shall be developed within 30 calendar days after an individual is transferred within the program. The program director will provide oversight to ensure this is completed in addition to a review of the developed individual program plan to provide any additional feedback to best care for the client.

Deficiency Cited: 63.15 (2) c Physical Examinations
63.15 (2) Each resident admitted to a residential care facility for the intellectually disabled shall have had a physical examination prior to admission.

Corrective Action Plan:
Going forward we will comply with code 63.15 (2) ensuring each resident admitted to the program shall have had a physical examination prior to admitting. Going forward the Administrator will work closely with the Clinical Evaluator to ensure the resident has had a physical examination prior to admission.

These corrective action plans will be in place 7/9/18 and will be monitored by the Administrator, Program Director and State Director.

Please feel free to contact me with any additional questions at 563-321-5706 or at Ashley.smith@neurorestorative.com

Sincerely,

Ashley Smith, MSM- State Director- Iowa

NeuroRestorative- Iowa