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
	770488	A. BUILDING: _____ B. WING _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITA HEALTH SERVICES	**1725 6TH AVENUE DES MOINES, IA 50314**

(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
R 000	Initial Comments No deficiencies were cited regarding investigations 98872-M, 98790-C and 98876-I or the onsite infection control survey. The following deficiencies were cited during the investigation of 98475-C.	R 000		
R 266	481-57.7(5)b General Requirements 57.7(5) The licensee shall: b. Be responsible for compliance with all applicable laws and with the rules of the department. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to comply with requirements related to notification to the Department found in Iowa Administrative Code 481-chapter 50. Findings include: 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). The administrator confirmed this finding. See deficiency under 50.7(4) for details.	R 266	The Plan of Correction is attached.	
R1024	481-57.34(3)c Safety 57.34(3) Resident safety. c. Residents shall receive adequate supervision	R1024		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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R1024	Continued From page 1 to ensure against hazard from themselves, others, or elements in the environment. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents received adequate supervision at all times affecting 1 of 3 residents reviewed (Resident #1). Findings include: 1. On 9/20/21 incident report review revealed on 7/08/21 at 8:00 a.m. Resident #1 was noted as missing from the facility. On 9/22/21 at 12:56 p.m. interview with the Staff C, who worked the overnight shift, confirmed she last spoke with Resident #1 at approximately 7:15 a.m. on the morning of 7/08/21. A missing persons report was filed with the police on 7/08/21. The police department called the facility around 12:00 p.m. on 7/08/21 to report Resident #1 was taken to the local hospital because the personnel at the store the resident had gone to could not understand what she was trying to buy. She was unresponsive to communication. The resident returned from the hospital on 7/08/21 at 6:15 p.m. with staff. It was later determined Resident #1 was mad at staff from a prior incident that occurred on 7/07/21. The resident was only allowed one soda a day as too much could cause seizures. On 7/07/21 she had too many sodas and was caught by staff and became physically agressive. 7/08/21. 2. A second incident report revealed Resident #1	R1024		

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R1024	Continued From page 2 had left the facility without staff on 5/20/21 at 3:15 p.m. and gone to the dollar store. 3. On 9/21/21 at 3:30 p.m. record review revealed Resident #1 had diagnoses including schizoaffective disorder and moderate intellectual disability. Resident #1 required a Laotian interpreter to communicate for understanding and assistance. She did not know how to read or write English. 4. On 9/23/21 at 9:36 a.m. interview with Staff E confirmed Resident #1 had left the facility a couple of times without staff. One time Resident #1 had gone to the gas station and the second time to the dollar store. On 9/20/21 at 3:15 p.m. the Administrator confirmed Resident #1 had left the facility on the morning of 7/08/21 without staff knowledge. The actual time she left was unknown. The Administrator reported Resident #1 had left the facility one other time but was reported to have been followed by staff during that incident. On 9/27/21 at 1:29 p.m. a follow up interview revealed she was not aware of the 5/20/21 elopement and had thought staff were with Resident #1 the entire time.	R1024		
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	C 147		

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C 147	Continued From page 3 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 with 24 hours or the next business day of elopements regarding 1 of 3 residents reviewed (Resident #1). Findings include: A review of incident reports revealed Resident #1 had walked away from the facility on 5/20/21 and on 7/08/21. Staff were not aware Resident #1 had left the facility either time. Resident #1's diagnoses included schizoaffective disorder and moderate intellectual disability. She spoke limited English and required an interpreter for full communication. She suffered no injuries on either occasion. On 9/27/21 at 1:29 p.m. the Administrator confirmed these elopements had not been reported to the Department. She had thought staff was with the resident on 5/20/21 when she left the facility and went to a nearby store. However, she knew staff was not with her on 7/8/21 but was not aware of the reporting requirement for elopements.	C 147		

Vita Health Services

Providing opportunities to Individuals in Need

The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel.

On 5/20/21 and 7/08/21 Vita Health Services experienced 2 elopements; the steps taken are listed below to make sure elopements with any of our members does not happen again.

- Vita Health Services and the ICP Team will assess the ability of all members in their ICP meeting upon admission. The need to access the extent and type of supervision per Vita's Provision of 24-hour supervision and authorization of exceptions policy on an individualized basis.
- All staff are to do hourly rounds for oversight protection per Vita Elopement Policy.
- Staff are to check on the outside premises to ensure no one is outside that can't be by themselves.
- There are at least 2 staff on 1st and 2nd shift. At least one staff are to be at the front desk when not doing rounds to ensure no one enters or leaves the premises.
- If the person can leave the premises by themselves staff are to sign the members out on the sign out sheet for Vita Health Services records.
- Cameras have been installed on all exit exteriors doors to help more in depth of supervision oversight.

These steps were taken for the safety of Vita Health Services residents. Vita Health will stay in conjunction with code rule **57.7(5)b** by following the above steps.

If an elopement happens Vita Health Services administrator is the designee that will be responsible for reporting all elopements within 24 hrs following code rule **50.7(4)** to the Department Inspection and Appeals. Steps are listed below.

- Once as staff member and or personnel notices a member that's no longer on the premises staff are to follow the elopement policy as stated:
    - Staff will do hourly rounds for each member being served in the Vita Health Services Residential Care Facility. While completing hourly rounds, staff MUST visually observe each member and their locations; this information must be recorded on the Vita Health Services Round

Sheet. If the member has signed out of the building, staff must record that information also on the sign out sheet. If the member is unable to be located, staff must begin to search the Vita Health Services premises for them. If the member is unable to be located per the 24-hour supervision policy pending on the severity of the persons ability to make decisions per their ICP, staff is to notify the Administrator of the elopement right away after filing out an incident report and routing it to the administrator

- The administrator then reports the elopement to the police
- The administrator will report the incident to the members guardian if applicable/ or the next emergency contact.
- The administrator then will report the incident to the Department of Investigation and Appeals by filling out a self-report on the DIA portal.
- ICP meeting will take place with Vita Health Services Administration team, Case Manager and any other supports needed such as a guardian as soon as the next earliest meeting can be set to discuss Behavioral Intervention Planning and updating ICP for resident safety.
- All restrictions will be identified in the members ICP
- All staff no matter the shift will be trained on any member support needs that's been updated in their ICP to better assist the members of Vita Health Services.
- All staff will then be retrained on elopement procedures.

The date by which the process will be in place will be no later than 10/01/2021 the re-training of the staff will be no later than 9/29/2021. The administrator of Vita Health Services will oversee to make sure the process is being followed.

Ok 3/4/22