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
	520457	A. BUILDING: _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM OAKS	4515 MELROSE AVENUE IOWA CITY, IA 52246

(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 The following deficiencies were cited during the investigation of Incident #84685-I.	R 000		
R 294	481-57.10(2)a Administrator 481-57.10(135C) Administrator. Each residential care facility shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these rules. 57.10(2) Duties of an administrator. The administrator shall: a. Select and direct competent personnel who provide services for the residential care program. (III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure staff were competent in their duties regarding supervision checks related to 1 of 1 residents identified in self-reported incident #84685 (Resident #1). Findings include: On 8/14/19 a review of incident reports revealed Resident #1 eloped from the facility on 7/14/19. Resident #1 was last seen eating lunch at approximately 11:30 AM. At 12:12 PM, an ambulance driver picked up Resident #1 along the highway and gave him a ride to the hospital per the resident's request. The resident returned to Chatham Oaks at 3:15 PM via cab per camera footage.	R 294	Plan of Correction is attached. 10/2/19	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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R 294	Continued From page 1 On 8/14/19 a review of safety head check data sheets revealed Staff C documented she saw Resident #1 in the courtyard at 12:00 PM, 1:00 PM, 2:00 PM and 3:00 PM. It was noted by administrative staff this documentation was not correct as Resident #1 was not inside or outside of the building at these times but had eloped and gone to the hospital, not returning until 3:15 PM. On 8/14/19 at 10:20 AM, the Director of Social Services stated Staff C was adamant she saw him during these times but confirmed it was not possible as the resident was not present. The Director of Social Services stated Staff C was going to receive disciplinary action regarding the matter, but never returned to work after the incident. Staff C's employment was terminated.	R 294		
R 412	481-57.12(1)s General Policies 481-57.12(135C) General policies. The licensee shall establish and implement written policies and procedures as set forth in this rule. The policies and procedures shall be available for review by the department, other agencies designated by Iowa Code section 135C.16(3), staff, residents, residents' families or legal representatives, and the public and shall be reviewed by the licensee annually. (II) 57.12(1) Facility operation. The licensee shall establish written policies for the operation of the facility, including, but not limited to the following: (III) s. Resident supervision; (II, III)	R 412		

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R 412	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility staff failed to follow internal policies on resident supervision for 1 resident reviewed (Resident #1) Findings include: On 8/14/19 a review of incident reports revealed Resident #1 eloped from the facility on 7/14/19. Resident #1 was last seen eating lunch at around 11:30 AM. At 12:12 PM, an ambulance driver picked up Resident #1 along the highway and gave him a ride to the hospital per his request. The resident returned to Chatham Oaks at 3:15 PM via cab per camera footage. According to the resident he went to the hospital as he could not stand the pain in his foot. On 8/14/19 a review of Resident #1's nurse's notes revealed Staff B met with Resident #1 after his return to discuss his programming and what he could have done differently. After that, Staff B checked on Resident #1 frequently for the first 3 hours to ensure his foot was not bothering him. On 8/14/19, a review of facility policies revealed a policy titled: "Resident Safety: Leaving Facility without Authorization." The policy stated the following actions would occur after a resident's return from an elopement: 1.) A heightened observation form will be initiated by the charge person immediately upon the resident's return. 2.) Staff will monitor the resident 1:1 for at least the first hour. 3.) After successful completion of 1:1 staffing, the staffing checks can move to 15 minute	R 412		

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R 412	Continued From page 3 checks. 4.) After successful completion of 15 minute checks, staffing checks can move to 30 minute checks. 5.) After successful completion of 30 minute checks, staffing checks can return to normal 1 hour checks. On 8/14/19 at 11:35 AM, the Director of Social Services stated Staff B contacted him as the on-call supervisor on the night of 7/14/19 to inform him staff forgot to formally document increased checks but that she herself had completed increased checks to ensure his foot was alright. Staff B did document her actions in the nurse's notes. A heightened observation form for Resident #1 following his elopement could not be located. On 8/14/19 at 12:00 PM, the Director of Social Services, Staff A, and the Activities Director confirmed staff did not follow the proper protocol for increased supervision on 7/14/19 per the facility policy.	R 412		

An Affiliate of UnityPoint Health

10/7/19 **Chatham Oaks, Inc.**

Residential Care Facility
4515 Melrose Avenue
Iowa City, IA 52246
(319) 887-2701
FAX: (319) 887-9154
abbehealth.org

September 16, 2019

Deb Dixon, Program Coordinator
Health Facilities Division
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

Re: Incident #84685-I

Dear Ms. Dixon,

In response to this investigation the following Plan of Correction steps are underway:

1. Retrain Direct Care staff on the Resident Rounds policy by 10/11/19.
2. Retrain Direct Care staff on the Resident Safety: Leaving Facility Without Authorization policy by 10/11/19.
3. Update our new hire training to ensure new Direct Care staff receive training on these policies before performing these tasks independently. This will be done by 10/11/19.
4. The Director of Nursing is responsible for the implementation of these corrective actions.

Thank you.

Sincerely,

Aaron Pauls

Aaron Pauls
Administrator

10/8/19