Iowa Health Care Association
Iowa Center for Assisted Living
Iowa Center for Home Care

RCF Survey Committee Report
RCF Regulatory Insufficiencies
January 2021

(Includes October & November data)

Total Surveys Reviewed: 9
Insufficiency Free Surveys: 0
Total Insufficiencies Cited: 16
Average Number of Insufficiencies Cited per Facility: 1.8
Total Fines: $17,450

# of Recertification surveys: 1 (0 insufficiency free)
# of Complaints/Incident Investigation surveys: 7 (0 insufficiency free)

C 147:
The facility failed to notify the Department of elopements regarding 2 of 5 residents reviewed. A resident left facility after supper and was gone for one and a half hours. Staff drove around looking for resident and found on a bench near the highway. Resident was brought back to facility. Resident who was placed on suicide watch eloped and was found and brought back to facility. Approximately one month later the same resident left facility and was found on the side of the highway running towards a van. One week later the same resident left the building, the police were called and a missing persons report was filed. Resident arrived back at facility. 2 weeks later the same resident left the facility and missing persons report was filed but was later found by staff and brought back to facility. Approximately 2 months later, the same resident eloped from the facility after dinner, then again 2 weeks after that. The facility did not notify the department with any of these elopements.

R266:
- The facility failed to comply with requirements related to notifications to the Department found in IAC 480-Chapter 50.
- The facility failed to report two elopements to the Department.

R 368:
- The facility failed to document and provide proper supervision levels for 1 of 3 residents. Staff placed resident in memory care unit at the table for meal and locked the brakes to the w/c, the staff heard resident moan and found resident on the floor close to table and wheelchair. The resident had head injury was sent to hospital, later died with death certificate stating cause of death as multiple blunt force injuries to her head/face due to or as a consequence of the fall.

R 373:

- Facility failed to correctly administer medication for 1 of 6 current residents, 3 of 4 former residents. "HOLD" was written on the MAR for 2 different medications for several dates, and no physician order was found to "HOLD “Admit orders were not processed correctly onto the MAR for a resident Several MAR gaps for a resident taking Clonazepam with lack of documentation and documentation stating that the med was "unavailable" and resident had negative outcome of not receiving the medication such as outbursts, physical aggression, and combativeness.

R 374:

- The facility failed to follow the general policies laid out in their COVID-19handbook. The appropriate PPE was not worn in a resident's room who had tested positive for COVID 19. Physician was not notified of a resident's fever of 100.9 when the facilities policy states that physician to be notified of temperature of 100.4 or greater. The resident was later found unresponsive and CPR was initiated, resident was declared deceased by paramedic with cause of death as Arteriosclerotic Cardiovascular Disease, surveyor asked DON why low-grade fever was not reported to the doctor and she stated it was not necessary and that she was unaware of anyone in the building with COVID-19.

R 582:

- The facility failed to immediately notify the primary care provider of change of condition for 1 of 5 former residents. Resident had low grade temp, was not participating in group. Resident was later found unresponsive and CPR initiated, and paramedic declared deceased.

R 642:

- The facility failed to complete an incident report for every unusual occurrence for 2 of 5residents. Incident report was not completed for resident who had eloped on 2 different occasions. Incident report not completed for resident elopements.
- The facility failed to complete incident reports for unusual occurrences affecting an unknown number of residents. It was reported by another resident that several of his peers were smoking marijuana and drinking alcohol in the facility grounds. No incident reports were completed.

R 830:

- The facility failed to ensure service plans included the date of initiation for 1 of 2 former residents reviewed and the anticipated duration of services for 1 of 2 former residents.
- The facility failed to include rights restriction in the Individual Person-Centered Service Plans of 2 of 5 residents. Restrictions included phone usage, phone charger, clothing in room, shoes for resident who had eloped.

R834:

- The facility failed to update the service plan as needs changed for 1 of 5 residents.
- The facility failed to amend the service plan as needed for 1 of 3 former residents. Resident with a known history of falls, sustained a fall outside of his room. He was assessed by the nurse, noting a skin tear had re-opened on his elbow. The nurse contacted physician and physician states if he fell again or could not walk to send to ER. Later that morning resident was leaning to left and not following verbal commands. He was sent to ER and passed away at the hospital. The death certificate states cause of death as a subdural hemorrhage as a consequence of a fall. The service plan for the resident mentioned a wheelchair and physical

therapy which was no longer active Staff indicated they performed increased supervision of him but the service plan did not identify what "increase d supervision" entailed.

- The facility failed to modify service plans as needs changed for 1 of 2 current residents

R 1042:

- The facility failed to ensure odors were kept under control for 1 of 8 residents reviewed. Strong urine odors from a resident's room, usually saturating mattress and garbage not empty.

R 1058:

- The facility failed to maintain the building in good repair. Vinyl floor down hallway was very worn from foot traffic, blue paint was flaking above the toilet in the handicapped bathroom, An electric junction box was pulled loose from the wall outside of a residents bedroom.