ICAL Survey Committee Report
RCF Deficiencies Report
2nd Quarter 2018

Total Surveys Reviewed: 12
Insufficiency Free Surveys: 5
Total Insufficiencies Cited: 37
Average Number of Insufficiencies Cited per Facility: 3.08
Total Fines: $12,150

Cited deficiencies included:

Tag	Description of Deficiency	Fine
481-50.9	• Failed to conduct DHS evaluation of employee convicted of a crime. • Facility failed to complete criminal and abuse background check for one employee.	
481-57.5(d)	Personnel-resident assaulted three other residents, was arrested, no contact order with three residents assaulted. Resident who assault was sitting in chair in hallway when victim walked by, and was assaulted again, other instances of violence with other residents (headlocks, etc.) Staff was shadowing another staff on her first day, was assigned 1:1 with violent resident when altercation happened, **$4,250 fine**	
481-57.7(5)c	Failed to ensure primary care provider orders were completed on a quarterly basis for 3 of 3 residents; orders were almost 4 months.	
481-57.11(3)	• Failed to complete background checks. • Facility failed to complete criminal background, abuse checks for one employee.	
481-57.11(6)	• Failed to conduct employee physical exams prior to hire	

	• Facility failed to ensure 3 staff received physical examination every four years.	
481-57.16	• Resident fell, was bruised, no indication this information was ever sent to physician • Medical exams: resident fell multiple times; fax to physician was not sent.	
481-57.17(1)o	Failed to ensure notation describing condition upon transfer was sent to physician	
481-57-17(1)r	• Personal property not documented upon discharge • Facility failed to document resident's personal property and medications upon discharge.	
481-57.17(3)	• Facility failed to ensure incident report completed for resident who fell and was inured • Incident record: No record of incident report for resident who had fallen. • Resident fell, care notes revealed bruising, no incident reports were completed. • Incident report: resident choked on PB sandwich; Heimlich performed, res lost consciousness and was taken to hospital, no incident report could be located.	
481-57.17	• Resident’s death not recorded; time, circumstances, etc. • Resident records: resident sent to ER for agitation, combativeness, injuries of unknown source; no documentation by the facility of resident's return via ambulance. • Facility failed to document date and time of resident's death.	
481-57.19(1)	• Unused, unlocked medication cupboard in med room with 11 tablets Clonazepam • Drug storage: facility failed to maintain record of quarterly pharmacy inspection reports complete to the last survey date of 3/30/16 to present. • Drugs: drug storage cart observed unlocked and unattended for 6 minutes. • Resident said to have consumed 10-12 ibuprofen tablets at a sitting, was sent to emergency room; said took meds out of facility vehicle when staff left him/her unattended	
481-57.19(4)	• Drugs: facility failed to ensure three residents swallowed medications when administered by staff	

	• Nurse signed off on med administration, but surveyor observed medications in cup.	
481-57.19(2)l	Drug safeguards: residents record showed order for nightly Albuterol administration; but was not included in the quarterly orders.	
57.21(1)	Education on sanitation and safe food handling to completed for two of three dietary personnel.	
481-57.22(3)c	• Did not develop service plan within 30 days of admission. • Facility failed to ensure service plans for new dietary restrictions were updated for two residents (change to mechanical soft meal). • Resident was "hearing voices," more frequently and more loudly, telling him to harm himself; service plan not amended to include auditory hallucinations.	
481-57.23(3)c	• Service plan-tenant told staff was having a panic attack, staff took knife, keys, chopsticks, etc., resident eloped, boxcutters found in duffle bag when found by police, service plan was not updated to reflect need to occasionally search room for self-harm items, • Care plan not updated to indicate resident should not go to appointments without staff or family escort.	
57.28(2)	Resident received insurance reimbursement check for $3,000, reported he cashed check and gave money to staff for safe keeping; put in locked desk drawer, was stolen	
57.29(5)	Facility administrator mistakenly transferred $14,000 in resident funds to pay facility insurance premium.	
481-57.34(3)c	• Safety-resident choked on PB sandwich, was on soft mechanical diet, which excluded peanut butter **$7,900 fine**. • Safety-Resident found doubled over, bleeding, had been assaulted. Video showed group of residents enter another resident's room where he was assaulted.	