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
	310829	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST FAMILY SERVICES - RCF	1160 SEIPPEL ROAD DUBUQUE, IA 52002

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R 000	Initial Comments No deficiencies were cited during the investigation of Incident 98663-I, Incident 98056-I, Complaint 97388-C, Incident 99325-I or the onsite infection control survey. The following deficiencies were cited during the survey conducted to determine compliance with licensing rules for a Residential Care Facility and Complaint 98175-C, Incident 98055-I, Complaint 96472-C and Complaint 98539-C.	R 000		
R 302	481-57.10(2)c(3) Administrator 57.10(2) Duties of an administrator. The administrator shall: c. Provide in-service educational programming for all employees with direct resident contact and maintain records of programs and participants. In-service educational programming offered during each calendar year shall include, at minimum, the following topics: (3) Meal time procedures/dietary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct an inservice regarding meal time procedures/dietary topics during the year 2020. Findings include: On 8/18/21, an inservice record review revealed no meal time procedures or dietary topic for an	R 302	The administrator shall develop an Inservice agenda to include meal time procedures and dietary topics. This will begin with our next inservice starting on 12/2/21.	

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

1/11/22

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R 302	Continued From page 1 inservice in 2020. On 8/25/21 at 11:00 am, the Administrator confirmed the finding.	R 302		
R 304	481-57.10(2)c(4) Administrator 57.10(2) Duties of an administrator. The administrator shall: c. Provide in-service educational programming for all employees with direct resident contact and maintain records of programs and participants. In-service educational programming offered during each calendar year shall include, at minimum, the following topics: (4) Resident activities. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct an inservice regarding resident activities during the year 2020. Findings include: On 8/18/21, an inservice record review revealed no resident activities training/inservice for 2020. On 8/25/21 at 11:00 am, the Administrator confirmed the finding.	R 304	The administrator shall develop an Inservice agenda to include resident activities. This will begin with our next inservice starting on 12/2/21.	
R 372	481-57.11(6) Personnel 57.11(6) Physical examination and screening. Employees shall have a physical examination no longer than 12 months prior to beginning employment and every four years thereafter. Screening and testing for tuberculosis shall be conducted pursuant to 481-Chapter 59. (I, II, III)	R 372	Physical examinations and screenings are a requirement before a staff person begins their employment here at HFS. Each staff person has a preemployment physical and initial TB test done at Tri-State Occupational Health here in Dubuque, IA	

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R 372	Continued From page 2 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 for personnel found in Iowa Administrative Code 481 - chapter 59. Findings include: A review of employee files revealed the facility failed to complete baseline TB screenings as required by Iowa Administrative Code rule 481-59.5(1) for 3 of 6 staff reviewed (Staff J, M, N). The Administrator confirmed this finding. See deficiency under 59.5(1)	R 372	Files will be keep here at the RCF and with HR upon hire so we will have knowledge of all staff to keep better track of new and existing hires beginning 1/1/21. TB clinics will be conducted quarterly for residents and staff separate from one another.	
R 373	481-57.11(7) Personnel 57.11(7) Orders for medications and treatments. Orders for medications and treatments shall be correctly implemented by qualified personnel. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all orders for medications were properly implemented/administered by qualified personnel for 1 of 6 residents reviewed (Resident #5). Findings include:	R 373	Staff were educated in November 2021 on who can administer medications and treatments and who fit the criteria of qualified personnel. Beginning 12/1/21, new interventions will be made from when a new admission takes place, the files for a new resident are placed with nursing. and they are making sure that all records They will ensure the records are properly recorded for staff to follow related to medications and treatments as they occur. This will ensure that all staff are updated as admissions happen. MARS will be reviewed monthly by nursing to ensure no gaps exist beginning 12/1/21.	

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R 373	Continued From page 3 According to a record review completed on 8/23/21, Resident #5 was admitted to the facility on 4/20/21 with diagnoses including generalized anxiety disorder, major depressive disorder with psychotic symptoms, PTSD (post-traumatic stress disorder), amphetamine disorder, alcohol use disorder, schizoaffective disorder, unspecified narcissistic personality disorder and antisocial personality disorder. On 8/23/21 at 1:52 pm, Resident #5 stated he took Suboxone for narcotic dependence. Resident #5 stated staff often had not given him the medication and he once went two days without it which made him physically sick. This occurred around May or June of 2021. Resident #5 stated he believed he did not get the medication as the facility was short on staffing and struggled getting people who could pass narcotic medications. Resident #2 added he had not had any problems getting his meds in the past month. On 8/23/21 at 1:32 pm, Staff O stated she was aware of a few incidents when a resident did not get their meds because no one who was qualified was there in order to administer them. On 8/23/21 at 2:28 pm, the agency's RCF/PMI Administrator stated she was aware of one incident when someone did not get their Suboxone because the medication administration staff called in sick. Neither Staff O nor the RCF/PMI Administrator could recall specifics as to which staff and residents were involved in these incidents. On 8/23/21, a review of Resident #5's medication administration records for May 2021 revealed the following documentation regarding his Bupren-Nalox (Suboxone). The medication	R 373		

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R 373	Continued From page 4 administration record indicated Resident #5 was to receive 8/2mg SL, one film twice daily. According to documentation, the medication was not documented as being given on: 5/8 (am dose), 5/9 (both am and pm dose), 5/11 (am dose), 5/13 (am dose), 5/18 (pm dose), 5/22 (pm dose), 5/24 (pm dose), 5/28 (am dose), and 5/29 (pm dose). Besides the gap of administration documentation for the Bupren-Nalox (Suboxone), there were also gaps in the following medications in May: - Eszopiclone (insomnia) tab 3 mg, one tablet daily at night - missing documentation on 5/7, 5/17 and 5/28. - Acamprosate cal (alcohol dependence) tab 333 mg, two tablets three times daily - missing documentation for 5/6 (one dose), 5/9 (one dose), 5/11 (one dose), 5/14 (one dose), 5/23 (one dose), 5/28 (one dose) and 5/30 (one dose). - Ferrous Sulfate tab 325 mg EC, one tablet twice daily with orange juice - missing documentation for 5/17 (one dose) and 5/28 (one dose). - Flutic/Salme AER 250/50, one puff every 12 hours - missing documentation on 5/9 (one dose), 5/17 (one dose) and 5/28 (one dose). - Vitamin C tab 500 mg, one tablet twice daily - missing documentation for 5/17 (one dose) and 5/28 (one dose). A review of Resident #5's medication administration records for June 2021 revealed his Bupren-Nalox (Suboxone) was not documented as being given on 6/2 (one dose), 6/11 (one dose), 6/21 (both doses) and 6/25 (one dose). Besides the gap of administration documentation for the Bupren-Nalox (Suboxone), there were also gaps in the following medications in June:	R 373		

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R 373	Continued From page 5 - Invega (schizophrenia) tab 3 mg, one tablet daily at night - missing documentation for 6/12, 6/17, and 6/28. - Sertraline (PTSD) tab 50 mg, one daily in am - missing documentation for 6/23 and 6/30. - Gabapentin (anticonvulsant) tab 800 mg, one tablet 3 times daily - missing documentation for 6/11 (one dose) - Gabapentin tab 800 mg, one tablet 4 times daily - missing documentation for 6/14 (one dose), 6/17 (one dose), 6/18 (one dose), 6/23 (one dose), 6/28 (one dose) and 6/30 (one dose). - Cetirizine HCL tab 10 mg, one tablet daily in am - missing documentation for 6/20, and 6/28. - Ferrous Sulfate tab 325 mg EC, one tablet twice daily with orange juice - missing documentation for 6/7 (one dose), 6/15 (one dose), 6/21 (one dose) - Vitamin C tab 500 mg, one tablet twice daily - missing documentation for 6/7 (one dose) and 6/15 (one dose). - Flutic/Salme AER 250/50, one puff every 12 hours - missing documentation for 6/7 (one dose) and 6/15 (one dose). - Paliperidone (schizophrenia) tab ER 3 mg, one tablet at bedtime daily - missing documentation for 6/7. - Zyrtec 10 mg, one tab daily in am - missing documentation for 6/5, 6/8, 6/19, and 6/21. - Remeron (depression) tab 30 mg, one and a half tab daily at night - missing documentation for 6/7. On 8/31/21 at 9:40 am, the Administrator confirmed the above findings and stated staff were to document a letter "R" if a resident refused the medication.	R 373		

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R 834	Continued From page 6	R 834		
R 834	481-57.22(3)c Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to update/amended the service plan as needs changed for 1 of 6 residents reviewed (Resident #2). Findings include: On 8/18/21 at 10:30 am, Resident #2 was	R 834	Orientation and Service Plans are developed initially upon admission and reviewed every 30 to 90 days unless a resident's condition warrants it to be done sooner. A member of our interdisciplinary team and a nurse practitioner review resident concerns each week as they occur. From there the IPP is modified to reflect any changes that are necessary and communicated to all staff involved in the resident's plan of care. This will initially be done by nursing and then communicated to social workers to initiate with their clients. This will start on 12/1/21.	

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R 834	Continued From page 7 observed in bed. On 8/19/21 at 12:40 am, Resident #2 was observed in bed. She received her medications while she stayed reclined in bed propped with pillows. During observations on 8/19/21 at 2:00 pm, Resident #2 was seen in bed with staff present assisting her with incontinence cares. On 8/19/21 at 12:40 pm during a medication pass in Resident #2's room, Staff C stated Resident #2 had incontinence issues. Resident #2 recently had begun staying in bed and complained of lethargy and knee pain. Staff C stated staff were not sure why she was like that. Testing done by her physician had come back normal. Staff C stated the facility was looking for a long term care facility for the resident due to her declining condition. On 8/19/21 at 12:11 pm, the Administrator stated Resident #2 used to be active and did well, but recently had begun to have concerns with knee pain, lethargy and staying in bed. On 8/23/21 during a record review for Resident #2, the service plan on file dated 7/22/21 had reflected the following condition of Resident #2: On 8/23/21 review of the resident's service plan dated 7/22/21 revealed Resident #2 stated during her last IPP meeting she had been doing good. The service plan reflected the resident was generally independent in activities, took her medications and completed hygiene practices well. The team discussed the resident moving to a group home. The service plan had not been updated to address the resident's needs as noted above.	R 834		

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R 834	Continued From page 8 On 8/31/21 at 9:30 am, the Administrator confirmed the service plan had not been amended as Resident #2's needs changed.	R 834		
R 985	481-57.32(5) Resident Abuse Prohibited 57.32(5) Staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide training relating to the identification and reporting of dependent adult abuse as required for 1 of 4 staff reviewed employed longer than 6 months (Staff N). Findings follow: Chapter 235B 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 three years using an approved curriculum. Review of Staff N's file revealed a hire date of 12/3/20. No record of dependent adult abuse training could be located. The Administrator on 8/25/21 at 11:20 a.m. confirmed this finding.	R 985	Training is expected to be completed by new and existing staff related to Identification and Dependent Adult Abuse within six months of initial employment and at least two hours of additional dependent adult abuse identification and reporting training every three years on the software program, Relias. Human Resources should have that information on all staff or be able to refer to a particular training through this software at any time to confirm completion. Monthly reviews will be done by nursing and this process will begin on 12/1/21.	
R1024	481-57.34(3)c Safety 481-57.34(135C) Safety. The licensee of a	R1024		

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R1024	Continued From page 9 residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II, III) 57.34(3) Resident safety. c. Residents shall receive adequate supervision 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 provide adequate supervision to ensure against hazard from themselves for 2 of 6 former residents reviewed (Resident C1 and Resident C7). Findings include: 1. On 6/23/21 a review of Resident C7's record revealed he was admitted on 7/1/20 with diagnoses including bipolar disorder and generalized anxiety disorder. A review of incident reports for Resident C7 revealed the following: - 6/4/21: Resident C7 eloped from the facility for the first time, during the overnight shift. No injuries were noted from the elopement. When he returned on his own the next morning, the following was put in place: 1.) two week restriction to the facility, increased 15 minute safety checks, and his elopement goal was revised to reflect actual elopement behaviors. Resident C7's physician was notified. - 6/8/21: Resident C7 eloped from the facility for the 2nd time, during the overnight shift. No injuries were noted from the elopement. When Resident C7 returned later that day, the following was put in place: Resident C7 continued with 15	R1024	A review of the elopement protocols were looked at after this incident and in addition to the other protocols and the particular circumstances related to the individual, the individual would be moved to safer, more secure setting after the first elopement. Staff training on all policies when someone displays these behaviors the service plan will be reviewed and revised. Review of resident incident reports and service plans will be done weekly by nursing. This process will begin 1/1/22.	

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R1024	Continued From page 10 minute safety checks, saw his personal physician on 6/9, and his two week facility restriction was extended. The service plan was only amended by adding the date of the 6/15/21 elopement. No changes were made regarding programming. -6/15/21: Resident C7 eloped from the facility for the 3rd time, during the overnight shift. No injuries were noted from the elopement. Resident C7 was found standing in front of the building next door. When he returned within 20 minutes, the following was put in place: Resident C7 continued with 15 minute safety checks and his two week facility restriction was extended. The service plan was only amended by adding the date of the 6/15/21 elopement. No changes were made regarding programming. -6/20/21: Resident C7 eloped from the facility for the 4th time, during the overnight shift. No injuries were noted from the elopement. When he returned from across the street, the following was put in place: Resident C7 continued with 15 minute safety checks until physician approved to move to the PMI unit of the facility. Resident C7's elopement behaviors diminished once he moved to a more secure setting. Although Resident C7 was moved to a more secure living environment after the 6/20/21 elopement, the facility failed to attempt new strategies to try to prevent the resident from eloping after the incident on 6/8/21. The follow-up actions the facility took were exactly the same as prior which had not proven successful in keeping him safe. 2. On 8/23/21, a review of Resident C1's record revealed an admission date of 4/20/21 with diagnoses including depression, PTSD (post-traumatic stress disorder), borderline personality, alcohol abuse disorder, psoriasis,	R1024		

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R1024	Continued From page 11 ADHD (attention deficit hyperactivity disorder) and anemia. The resident's service plan indicated she struggled with suicidal ideations. She was living in a group home when she attempted to harm herself with a razor blade by making superficial lacerations to her arms and attempted to cut her neck. A notation typed by Staff Q describing an incident that occurred on 5/6/21 documented the following: "Around 7 pm, Resident was wanting this nurse to check her pulse, because she had stated she felt her pulse beating fast. This nurse checked resident's pulse it was 99. Later on Resident had complained of being dizzy so this nurse decided to check Resident's blood pressure it was 144/90. Resident sat down and drank a glass of water and then stated the dizziness had subsided. Around 9:40 pm, this nurse was paged to the tech station where staff told this nurse to grab gloves and go to the resident's bathroom. Once to the resident's bathroom, this nurse observed Resident laying on her bathroom floor with a needle in her left antecubital vein and a large amount of blood on the bathroom floor. This nurse did not move the needle. At this point Resident was breathing and conscious but would not respond to this nurse from being very weak. 911 was called. This nurse asked Resident where she had gotten the needle from. Resident faintly stated that she got them off of Amazon. This nurse asked Resident if she had more needles, and Resident stated, yes. This nurse asked Resident if she could tell me where the needles were, and she stated, no. This nurse asked if we could search resident bedroom later, Resident stated, yes. This nurse tried to keep Resident talking so that she would not go unconscious. Resident stated that she had done this a few	R1024		

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R1024	Continued From page 12 times this evening in her bathroom. Once EMS and fire department arrived this nurse observed Resident leaving for Mercy Dubuque ER at 10:10 pm." Staff Q later documented a second note on 5/7/21 at 4:40 pm after receiving an update from the hospital. The note documented the following: "Received a call from the Mercy ER nurse stating that resident would be admitted to the hospital. The nurse stated the resident was in critical condition due to losing so much blood and that she would also have to have a blood transfusion. The nurse also wanted to report that resident had come to the hospital with a big package of needles ranging from 14g, 16g, 18g, and 20g. Resident had told the ER nurse that staff did not check her mail and just gave her the needles to take to her bedroom." A notation from hospital records (admitted: 5/7/21, discharged 5/7/21) revealed the resident stated she had ordered 100 piercing needles for 12 dollars from Amazon online. Resident C1 stated she opened the package in front of staff as required, but they had either not recognized or had not seen the needles. Staff I was unavailable for interview but did provide a written statement on 8/26/21 at 2:20 pm. She documented Resident C1 opened the package in front of her. She did not see any needles in the box. She said the resident later admitted she was sneaky about the way she opened the box and made it look like she took everything out, but she didn't. A review of the facility Residential Handbook revealed mail is delivered Monday through Friday at various times during the day, excluding	R1024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310829	A. BUILDING: _____ B. WING _____	C 09/02/2021

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R1024	Continued From page 13 holidays. Mail is distributed at the tech stations. All packages for clients are to be opened at the tech station with staff supervision for the safety of clients and others. Although staff did follow appropriate procedures for resident mail according to the Residential Handbook, the resident was still able to sneak the needles from the package to her room. Staff was not observant enough to discover the piercing needles that were in the package. 3. On 8/31/21 at 9:30 am, the Administrator confirmed the above findings.	R1024	While staff did follow appropriate procedures for resident mail, the resident was still able to sneak the items from the package to her room. we will endeavor to be more thorough when we do our inspections as the mail is opened up in front of us moving forward. Review procedures and revise policy, retrain staff to include having residents take all items out. Administrator or designee will oversee beginning on 12/1/21.	
V 145	481-59.5(1) Baseline TB Screening Procedures for Faciliti 59.5(1) All HCWs shall receive baseline TB screening upon employment. Baseline TB screening consists of two components: (1) assessing for current symptoms of active TB disease and (2) testing using the two-step TST procedure or a single IGRA to screen for infection with M. tuberculosis. If the first-step TST result is negative, the second stage of the two-step TST is recommended one to three weeks after the first TST result was read. Administration of the second stage of the two-step TST shall not exceed 12 months after the first TST result was read. If initiation of the second stage of the two-step TST is greater than 12 months from when the first TST result was read, the two-step procedure must be restarted. If the first-step TST result is positive, it is not necessary to perform the second stage of the two-step TST. This REQUIREMENT is not met as evidenced by:	V 145	Physical examinations and screenings are a requirement before a staff person begins their employment here at HFS. Each staff person has a preemployment physical and initial TB test done at Tri-State Occupational Health here in Dubuque, I Files will be keep here at the RCF and with HR upon hire so we will have knowledge of all staff to keep better track of new and existing hires beginning 1/1/21. TB clinics will be conducted quarterly for residents and staff separate from one another so to ensure that those needing to complete a second stage will get it completed. TB screens will be completed with two step process and TB testing will be overseen by nursing and HR and reviewed monthly beginning on 12/1/21.	

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V 145	Continued From page 14 Based on interview and record review, the facility failed to complete the two-step TST (tuberculin skin test) for 3 of 6 employees reviewed (Staff J, M, N). Findings include: Record review on 8/19/21 of employee files revealed the following: - Staff J was hired on 7/11/20. The first half of the two-step TST was completed on 7/3/20. The second half of the two-step TST was not on file. - Staff M was hired on 8/24/20. The first half of the two-step TST was completed on 8/5/20. The second half of the two-step TST was not on file. - Staff N was hired on 12/3/20. The first half of the two-step TST was completed on 11/19/20. The second half of the two-step TST was not on file. On 8/25/21 at 11:20 am, the Administrator confirmed the finding.	V 145		