CAC 8/10/16 √ 8/12/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G052	A. BUILDING _____ B. WING _____	C 06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-BIRCH COTTAGE	29 EAST STREET SHELBY, IA 51570

(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) COMPLETION DATE
W 000	INITIAL COMMENTS At the time of the investigation of self-reported incidents #61024-I, standard-level deficiencies and condition-level deficiencies were cited. Conditions of Participation were cited at W102. Standard-level deficiencies were cited at W125 and W262..	W 000	Please see attached. POC 8/15/16	
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to be in substantial compliance with the Condition of Participation (COP) - Governing Body and Management. The governing body failed to take action that identified, addressed and/or resolved problems of a serious and recurrent nature, which directly impacted a client's safety and well-being. This pertained to 1 client (Client #1) identified in investigation #61024-I. Findings follow: 1. The Governing Body failed to consistently develop, monitor and revise policies and direction to provide for clients' safety. See W104	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy,	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PD — (X6) DATE: 8/11/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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budget, and operating direction over the facility.

This STANDARD is not met as evidenced by:
Based on observation, interviews and record review the facility failed to develop policies and monitor condition of equipment required to provide safety for 1 client (Client #1) identified in investigation #61024-I. The involved staff also failed to follow facility policy. Findings follow:

Record review on 6/27/16 revealed a facility investigation initiated on 6/2/16 completed by the Program Director (PD). The document contained interviews of all persons involved and documented the following: "On Thursday morning 6/2/16, (Client #1) had an unobserved elopement from Birch. (Client #1) was last observed by the facility staff at 5:00 a.m. and they were informed that (he/she) was at the Corn Crib at approximately 5:30 am. The police returned (Client #1) to the facility around 6:00 am. The door alarms in Birch were not turned on at the time of (Client #1's) elopement. (Client #1) had no injuries as a result of this incident. Law enforcement was involved in locating and returning (Client #1) to the facility." "A door alarm inspection/tracking sheet is being implemented for Birch staff to ensure that all alarms are on and functioning."

According to Client #1's Individual Information Sheet he/she was 55 years old with the following diagnoses: Schizophrenia with paranoia, depression, hypertension and hyperlipidemia. The information sheet included independent mobility and physical and verbal aggression along with history of elopement.

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According to his/her Plan of Care (POC) completed on 3/4/16 Client #1 lived at Birch since 2/1/2013. The POC also identified priority needs of aggression, elopement, eating at an appropriate pace and laundry skills. The safety plan assessed the client' s community awareness and identified the following: "Staff will assist (Client #1) to remain safe while in the community. (Client #1) will understand stranger danger while out in the community. (Client #1) will be assisted in when to cross the street/parking lot." The POC stated the review was completed by the PD with the summary completed by the Qualified Intellectual Disability Professional (QIDP).

Record review on 6/27/16 revealed an Individual Incident Report completed 6/2/16 at 5:32 a.m. The report, completed by the QIDP stated he completed the 5:30 a.m. bed check and could not find Client #1. He searched the house and area and called the dispatcher. The dispatcher later called to report Client #1 was located at the Corn Crib (a local restaurant) and he/she would be returned by the authorities.

The report documented Client #1 did not receive any injuries during the elopement. It also stated the QIDP contacted the PD at 11:00 a.m. The PD wrote QIDP "admitted the alarms were not on and should have been. Follow up with staff and training to occur regarding this. Alarm tracking sheet to be implemented at this program."

Observation on 6/27/16 at 1:00 p.m. revealed alarm devices on all three exits doors of the facility. The west door contained a 5 inch by 3 inch white rectangular box on the outer edge of the door. A small 1/2 inch by 1 inch device

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aligned to the frame of the door. The alarm rang when the door opened. The south door contained the same alarm system and rang when the door opened. Each of these two devices had a sliding lever which easily disarmed the device when moved to the right. The north door contained a 3 inch by 1 inch white device on the door with a smaller plastic piece on the door frame. The right side of the large piece contained a small slide to easily disengage the alarm. During observation this alarm also rang when the door opened.

Observation of the area on 6/27/16 at 3:00 p.m. revealed a paved driveway at the facility leading to the blacktop. The blacktop speed limit was posted at 35 miles per hour (mph). Across the blacktop approximately 500 yards from the Birch home was the Corn Crib restaurant. The ditches between the two buildings were mowed without large holes/rivers or lakes. Approximately 1/4 mile further south was Interstate 80 with a speed limit of 70 mph.

Observation on 6/28/16 from 6:00 a.m.- 6:35 a.m. revealed 8 cars and a semi-truck on the blacktop.

According to the Consumer Bed Checks for the night of 6/1/16 - 6/2/16 QIDP documented Client #1 as sleeping at 5:00 a.m. and awake at 5:30 a.m.

When interviewed on 6/27/16 at 11:30 a.m., the PD confirmed two clients required door alarms for history of elopement. She explained the QIDP worked the night shift on 6/1/16-6/2/16. The QIDP went to the kitchen to prepare lunches and when the QIDP completed the 5:30 a.m. check Client #1 was gone. The QIDP searched the

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house and area and did not find the client. He called 911. The client was located at a nearby restaurant and returned.

The PD denied being notified of problems with the alarms. She denied knowledge of clients turning the alarms off. She denied having a policy for the use of the alarms, routine monitoring of the alarms or direction for staff if problems arose. She denied initiation of a monitoring inspection sheet since the incident occurred 25 days prior. She confirmed Client #1 would not be safe in the community alone.

She said this was the only time Client #1 left the building unattended, usually he/she would threaten to leave or walk out the door with staff. He/she would walk around and return with staff. She denied any other clients eloping from the facility. She stated the QIDP did not notify her of the elopement until approximately 9:30 a.m. when he was leaving work. She confirmed the policy stated notification within an hour of the elopement.

Record review on 6/27/16 revealed Client #1's Individual Program Plan (IPP). The goal addressed reducing acts of elopement. The plan included use of door alarms stating, "Alarms on all exits of the home that will notify staff that the door has been opened." Additional information on the IPP stated (Client #1) "has a history of eloping and turning the alarms off."

Interview by phone with the QIDP on 6/27/16 at 12:10 p.m. revealed he no longer worked at the facility. He stated Client #1 was up and in his/her room prior to 5:30 a.m. The QIDP went to the kitchen to prepare lunches and did not hear any

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noise. He completed the 5:30 a.m. check and could not find Client #1. He looked around the house and area and called 911. The client was located at the Corn Crib and returned by 6:05 a.m. He thought the alarms were on, but confirmed all of the alarms were off at the time. He stated the alarms were on for the 2-10 shift, because he had worked that shift also. He denied turning the alarms off. He explained Client #1 turned off the alarms in the past, by sliding the lever to the right. When he would see Client #1 turn off the alarm he (the QIDP) would just turn it back on. He denied anyone entering the house and turning the alarms off. He explained he had talked to the PD about an alarm system that clients couldn't disengage. He denied any inspection/monitoring of the alarms.

When interviewed on 6/27/16 at 3:30 p.m. Direct Support Professional (DSP) A confirmed she worked the p.m. shift with QIDP on 6/1/16. She stated the alarms were on during that shift. She explained Client #1 knew how to turn off the alarms and at times would rip the whole assembly off the door. She said she turns the alarms back on or put the assembly back on the door when this would occur. She denied any monitoring/checking sheet or log to routinely check the status of the alarms. She stated she had notified the PD in the past about Client #1 turning off the alarms.

Interview with DSP B on 6/27/16 at 2:00 p.m. revealed she had worked at Birch for over a year. She stated Client #1 turned off the alarms and "messed with them" since she started there. She stated "The most we can do is turn them back on." She also stated another client kicks the door and the assembly falls off. The maintenance man

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replaces it or the staff fix it. She had told the QIDP about Client #1 shutting off the alarms. She denied a routine check of the status of the alarms.

When interviewed on 6/27/16 at 3:45 p.m. DSP C admitted Client #1 shut the alarms off "if (he/she) was tired of listening to them." The client would also destroy the alarms in the past. She stated she was trained to make sure the alarms were on when you came to work every day, but denied a monitoring sheet for routine checking. She stated the on call was to be notified if a client went missing.

Interview with DSP D 6/27/116 at 4:00 p.m. confirmed she had seen Client #1 turn off the alarms. She was not aware of any routine check of the alarms.

When interviewed on 6/27/16 at 4:35 p.m. DSP E explained Client #1 took down the door alarm in the past and broke it. She stated he/she had also tore off the small part of the device and lost it once. She denied any routine monitoring. She did not think Client #1 would be safe alone in the community.

Interview with the maintenance man 6/28/16 at 10:00 a.m. confirmed he would be notified of the alarms not working properly. He stated usually it would be the batteries. He was notified by a maintenance log that the staff wrote the problem in. He denied completing routine checks on the condition of the alarms. He admitted the present door alarms could be easily shut off.

The owner of the Corn Crib restaurant interviewed on 6/27/16 at 2:45 p.m. confirmed he

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went to the restaurant after he received a call from his staff about 5:30 a.m. The staff gave Client #1 a donut and Client #1 served him/herself a pop. Client #1 wore casual clothes, shoes and socks. The Pottawattamie County officer arrived and took Client #1 back to the facility.

Record review on 6/28/16 revealed a Service Agreement signed by Client #1's guardian. The Service agreement included Individual Rights Statement. The list of rights included: the right to a safe and sanitary living environment.

Observation on 6/28/16 at 8:10 a.m. revealed the south entrance door alarm failed to ring as the door was opened by the surveyor. DSP B commented that the door "must not have been shut completely", "It has to line up for it to chime" she added. The surveyor closed the door completely and the alarm rang as the door reopened.

Record review revealed Client #1's Comprehensive Functional Assessment (CFA) completed 3/3/16. The assessment indicated he/she could not complete the following community living skills: makes a shopping list, selects items on a shopping list, selects items for purchase, makes purchases at the store, stays within budget when shopping, knows where to purchase items, uses banking facilities/business office, budgets money, can make change for a dollar, exchanges money for desired object, places correct amount of money in vending machine. The CFA also identified "has a history of elopement."

Review of facility policy/procedures on 6/28/16

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W 104	Continued From page 8 revealed a Missing Persons Policy, last revised 1/1/15. The policy stated "Whenever possible, the program director or on-call program director shall by (be) contacted by supervisory personnel within one hour after the individual is discovered missing." In summary, the facility failed to provide the involved client with the safety devices required to keep him/her safe. All three alarms were off when the client left. According to Client #1's IPP the alarms were part of his/her plan of care. The facility failed to have a policy/procedure regarding alarms for staff direction. The facility failed to routinely monitor the devices. After the elopement an inspection sheet was to be started, however failed to be initiated. Staff interviews revealed it was common knowledge that the client disengaged the system. However, the system continued to be used. Staff would just turn the alarm back on. The facility failed to change the devices to a secure alarm system. The involved staff failed to notify the PD within an hour of the time the client went missing.	W 104		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.	W 125		

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This STANDARD is not met as evidenced by:
Based on observations, interviews, and records review the facility failed to ensure individual client rights as evidenced by denial of access to areas of their homes and personal items. This potentially affected 8 of 8 clients (Clients #1-#8). Findings follow:

1. Observation on 6/28/16 at 5:20 a.m. revealed kitchen door to dining room locked. Direct Support Professional (DSP) F explained it was locked because Client #3 was up. At 5:30 a.m. the door was unlocked. DSP F stated he kept the door locked if he was in with Client #4 doing personal cares because he couldn't hear the back door alarm in the clients room. He stated he had talked to the Program Director about locking the door and she said to use his best judgement. At 5:45 a.m. DSP F unlocked the kitchen door and Client #3 darted into the kitchen and tried to get food. No cooking was being completed and no knives were on the counters. At 5:50 a.m. Client #3 barged into the kitchen and opened and spilled pop on the floor. Client #3 continually attempted to get into kitchen.

At 6:20 a.m. the kitchen door remained locked as Client #3 wandered around dining room trying to get into the kitchen. DSP unlocked the kitchen door at 6:50 a.m.

Further observation on 6/28/16 at 6:15 p.m. revealed kitchen door locked while DSP G prepared the evening meal with pans on the stove. DSP C explained the door was locked because Client #3 liked to go in the kitchen and the stove was on. She stated it was locked to prevent injury since the stove was on. Client #3 tried to get into the kitchen many times, however

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W 125	Continued From page 10 the door remained locked until 6:20 p.m. When interviewed on 6/28/16 at 11:45 a.m. the Program Director stated the kitchen doors could be locked for safety if the stove was on or if knives were out. She denied any program for the restrictive measure. 2. Observation on 6/28/16 at 5:25 a.m. revealed Direct Support Professional (DSP) F handed Client #1 two small med cups and explained one was body wash and one was shampoo prior to clients' shower. Observation on 6/28/16 at 6:10 p.m. revealed DSP C unlocked a small closet, placed a small amount of liquid in two med cups and handed cups to Client #5 before a shower. DSP C stated the liquid was body wash and shampoo. She explained the clients would dump it down the drain so the staff kept it in the locked closet and gave it to each client as they showered. She denied any clients having their own shampoo or body wash. Record review on 6/28/16 revealed an environmental modification letter to all guardians. The letter stated "The kitchen door is only locked when the stove is on and when there is no staff in the kitchen." The letter lacked indication of locked shampoo and/or body wash for each client. Interview on 6/29/16 at 9:10 a.m. with the PD confirmed she did not know the body wash and shampoo was locked in the closet. She was aware of them "rationing it" because the clients were using too much. She denied any client programs to learn to measure the products.	W 125		

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W 262	Continued From page 11	W 262		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to consistently review and obtain approval from the specially constituted committee (Human Rights Committee (HRC) for all restrictive measures/behavior modifying medication. This affected 1 of 1 (Client #1) identified in #61024-I. Findings follow: Record review on 6/27/16 revealed Client #1's Informed Consent for behavior modifying medications (Ability, Lithium, Atarax, Divalproex and Klonopin). The consent also included restrictive measures such as physical escort, observational time apart and manual restraint. The consent was signed by the guardian, however lacked signatures of the HRC approval. When interviewed on 6/27/16 at 11:30 a.m. the Program Director confirmed the written informed consent lacked signatures from HRC.	W 262		

Accept this plan as the facility's credible plan of compliance

W102: Facility Response:
The facility Program Coordinator, Lead Direct Support Professional, and Program Director/QIDP will work together to ensure that action is taken to address and/or resolve any problems of a serious or recurrent nature which directly impacts the safety and well-being of individuals in services. This was reviewed with all facility supervisors at team meeting on July 28, 2016.

Correction Date: 7/28/16

W104: Facility Response:
The facility Program Coordinator, Lead Direct Support Professional, and Program Director/QIDP developed a general policy and procedure for checking and maintaining facility door alarms and will ensure they are functioning at all times and monitoring system is implemented. All staff have been trained on this policy. Staff have also been retrained on the Missing Person Policy.

What is monitoring when frequency?

Correction Date: 6/28/16

W125: Facility Response:
The facility Program Coordinator, Lead DSP, and Program Director/QIDP will ensure that each client is able to exercise their rights to access items in their homes. The need for locks on the kitchen door will be evaluated. If determined to be necessary, programming will be developed and implemented and consent will be obtained from guardians. Shampoo and soap has been removed from the locked closet and clients will be able to access these and keep them in their shower caddies.

monitoring for compliance

Correction Date: 8/15/16

W262: Facility Response:
The facility Program Coordinator and/or Program Director/QIDP will ensure that all consent is obtained from all members from the HRC as well as guardians before implementing restrictive measures. Consents for all individuals identified have been updated and are now in place with proper consent and signatures.

monitor.

Correction Date: 7/1/16

Accept this plan as the facility's credible plan of compliance

W102: Facility Response:
The facility Program Coordinator, Lead Direct Support Professional, and Program Director/QIDP will work together to ensure that action is taken to address and/or resolve any problems of a serious or recurrent nature which directly impacts the safety and well-being of individuals in services. This was reviewed with all facility supervisors at team meeting on July 28, 2016.

Correction Date: 7/28/16

W104: Facility Response:
The facility Program Coordinator, Lead Direct Support Professional, and Program Director/QIDP developed a general policy and procedure for checking and maintaining facility door alarms and will ensure they are functioning at all times and monitoring system is implemented. All staff have been trained on this policy. Staff have also been retrained on the Missing Person Policy.

Correction Date: 6/28/16

W125: Facility Response:
The facility Program Coordinator, Lead DSP, and Program Director/QIDP will ensure that each client is able to exercise their rights to access items in their homes. The need for locks on the kitchen door will be evaluated. If determined to be necessary, programming will be developed and implemented and consent will be obtained from guardians. Shampoo and soap has been removed from the locked closet and clients will be able to access these and keep them in their shower caddies.

Correction Date: 8/15/16

W262: Facility Response:
The facility Program Coordinator and/or Program Director/QIDP will ensure that all consent is obtained from all members from the HRC as well as guardians before implementing restrictive measures. Consents for all individuals identified have been updated and are now in place with proper consent and signatures.

Correction Date: 7/1/16

VJK 8/10/16 CAC 8/10/16

Accept this plan as the facility's credible plan of compliance

W102: Facility Response:
The facility Program Coordinator, Lead Direct Support Professional, and/or Program Director/QIDP will work together to ensure that action is taken to address and/or resolve any problems of a serious or recurrent nature which directly impacts the safety and well-being of individuals in services, specifically reviewing processes surrounding door alarms and monitoring. This was reviewed with all facility supervisors at the team meeting on July 28, 2016. The monitoring of alarms and proper functionality will be tested on each shift and documented accordingly. Staff have been directed to notify leadership personnel in any situations where the alarms are not working properly, so that maintenance personnel can be notified as needed for repairs. Increased supervision will be provided until alarms are once again working properly. The documentation for the door alarms will be reviewed at a minimum of monthly and any concerns and/or issues will be followed up on to ensure proper function and/or provide additional training for staff. Additionally, the facility is in the process of evaluating and testing different types of door alarms that can be used that are more tamper resistant.

Correction Date: 7/28/16

W104: Facility Response:
The facility Program Coordinator, Lead Direct Support Professional, and/or Program Director/QIDP developed a general policy and procedure for checking and maintaining facility door alarms and will ensure they are functioning at all times and the monitoring system is implemented. All staff have been trained on this process and have been directed to notify leadership personnel in any situations where the alarms are not working properly, so that maintenance personnel can be notified as needed for repairs. Increased supervision will be provided until alarms are once again working properly. The documentation for the door alarms will be reviewed at a minimum of monthly and any concerns and/or issues will be followed up on to ensure proper function and/or provide additional training for staff. Additionally, the facility is in the process of evaluating and testing different types of door alarms that can be used that are more tamper resistant. Staff have also been retrained on the Missing Person Policy. Any time there are any concerns with the proper implementation of this procedure, staff training and/or performance feedback will be provided to ensure compliance. On the spot feedback/training will occur, as well as this is a standing discussion topic on the monthly staff meeting agenda.

Correction Date: 6/28/16

W125: Facility Response:
The facility Program Coordinator, Lead DSP, and/or Program Director/QIDP will ensure that each client is able to exercise their rights to access areas and items in their homes.

The need for locks on the kitchen door will be evaluated. If determined to be necessary, programming will be developed and implemented and consent will be obtained from guardians. This and other restrictive measures in the program will be reviewed on a monthly basis when data summaries are completed, at least twice per year in conjunction with the Human Rights Committee meetings, at least twice per year when informed consents are reviewed in the quarters that HRC meetings are not held and annually at the time of each individual's Plan of Care (POC) meeting. Shampoo and soap has been removed from the locked closet and clients will be able to access these and keep them in their shower caddies. Staff have been reminded that restrictions such as this, even with good intent, are still restrictive in nature and thus should not occur unless the proper approvals and programming are implemented. These types of restrictions will be addressed on an on-going basis, if they should occur and the proper follow up to eliminate the restriction and/or obtain the proper approvals and documentation to support the restriction.

Correction Date: 8/15/16

W262: Facility Response:

The facility Program Coordinator and/or Program Director/QIDP will ensure that all consent is obtained from all members from the Human Rights Committee HRC as well as guardians before implementing restrictive measures. Consents for all individuals identified have been updated and are now in place with proper consent and signatures. All restrictive measures, including behavior modifying medications, that are outlined in the individual Informed Consent packets, will be reviewed at least twice per year in conjunction with the Human Rights Committee meetings, at least twice per year when informed consents are reviewed in the quarters that HRC meetings are not held and annually at the time of each individual's Plan of Care (POC) meeting. This will ensure that all restrictions are approved, programmed for, implemented and have the signed approval of the guardians and the HRC members.

Correction Date: 7/1/16
