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 10/27/2016

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 incident #63854-I, standard-level deficiencies and a Condition of Participation (COP) were cited. Condition of Participation was cited at W102. Standard level deficiencies were cited at W104, W125, W234 and W289.	W 000	See attached	
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 staff 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 ensure implementation of appropriate levels of supervision which directly impacted a client's safety. This affected 1 client identified during the investigation of #63854-I (Client #1) and potentially affected all clients living in the facility. These findings led to a determination of Immediate Jeopardy. Findings follow: Cross reference W104. Based on interviews and record review, the facility failed to consistently implement policies and procedures and provide adequate operating direction to address and ensure provision of a safe environment. Cross reference W234. Based on interviews and	W 102	POC 12/18/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Regional Director — (X6) DATE: 11/28/16

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.

ICF/ID Program Coordinator
Special Services Bureau
Health Facilities Division
515-281-3759
catie.campbell@dia.iowa.gov

Enclosures: Statement of Deficiencies
and Plan of Correction

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W 102	Continued From page 1 record review, the facility failed to ensure each Individual Program Plan (IPP) specified client supervision levels to maintain client safety.	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to consistently implement policies and procedures and provide adequate operating direction to address and ensure provision of a safe environment. This affected 2 of 2 clients with elopement behavior at the time of the investigation of incident #63854-I (Client #1 and Client #2) and potentially affected all clients residing in the facility. Findings follow: 1. Record review on 10/25/16 revealed an Individual Incident Report of Client #1's elopement from the facility on 10/20/16. The report written by Direct Support Professional (DSP) A noted he conducted bedroom checks at 12:00 a.m. on 10/21/16 and discovered Client #1 missing. DSP A checked the bathroom across the hall because he had seen Client #1 go into the restroom at approximately 11:45 p.m. on 10/20/16. DSP A searched the house and found the door at the west end of the building partially open. He noted the alarm on the door had been turned off though the alarm worked when he checked it earlier in the evening. DSP A called supervisory and direct support staff to assist in a search for Client #1. DSP A documented DSP B found Client #1 by a gas station near the facility	W 104		

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W 104	Continued From page 2 and brought him/her back to the facility. Further record review revealed the facility Individual Diagnosis form. Client #1's diagnoses included: Moderate intellectual disability, Schizophrenia-Chronic Paranoid, Dementia, Anxiety, Hypertension, History of Obsessive Compulsive Disorder, History of Bi-polar Disorder, Gastroesophageal Reflux disorder (GERD), History of sleep apnea, Insomnia, Depression, Early Periodontal Disease, Asymmetric Neurosensory Hearing Loss, Parkinsonism related to schizophrenia medications, History of urinary retention, History of left rotator cuff repair and history of left ulnar release. Additional record review revealed Client #1's Individual Information Sheet. According to the document, Client #1 was 55 years old, communicated verbally and walked independently. Behaviors of concern included physical and verbal aggression toward others and a history of elopement. A photo on the document, taken 1/6/15, revealed Client #1 wore glasses. Continued record review revealed Client #1's Comprehensive Functional Assessment (CFA) dated 3/3/16. The CFA included a list of maladaptive behaviors and noted Client #1 engaged in elopement behavior. A written note documented Client #1's history of elopement and staff direction to him/her to obtain approval prior to leaving the building. The CFA contained no assessment/information regarding Client #1's ability to safely cross a street. Review of Client #1's Plan of Care (POC) held on 3/4/16 revealed the following documentation, "(Client #1) will be assisted in when to cross the street/parking lot." Further review revealed Client #1's Individual	W 104		

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W 104	Continued From page 3 Program Plan (IPP) to reduce acts of elopement. Possible behaviors included threatening to elope, observed elopement (defined as leaving the facility grounds with staff knowledge) and unobserved elopement (defined as leaving the facility without staff knowledge). Restrictive measures included use of a physical escort to direct Client #1 to a safe area, behavior modifying medications and use of alarms on all exit doors in the home and on Client #1's bedroom door. The IPP directed staff to check on Client #1 every 5 minutes when he/she attempted to elope, and failed to define any other level of supervision. Review of the Individual Program Data Summary revealed Client #1 made two threats of elopement in July and one threat in August. In September, he/she threatened to elope 10 times and left the building observed by staff five times. The data summary noted "a significant increase" in the behaviors. Despite the noted increase, no changes or interventions were recommended by the reviewer. Review of raw data for October revealed Client #1 left the building observed by staff on 10/1/16 at 3:15 p.m., on 10/8/16 at 6:20 p.m., on 10/16/16 at 10:50 p.m., twice on the evening shift on 10/17/16 (no time noted) and once on 10/18/16 at 7:00 p.m. Client #1 demonstrated observed elopement behavior five times prior to eloping at approximately 11:45 p.m. on 10/20/16. Review of the facility Consumer Bed Checks document on 10/25/16 revealed DSP A documented Client #1 "awake" from 10:30 p.m. - 11:30 p.m., "ran off" from 12:00 a.m. - 12:30 a.m., "awake" at 1:00 a.m. and "sleep" from 1:30 a.m. - 5:30 a.m.	W 104		

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W 104	Continued From page 4 Further record review revealed an "Alarm Inspection Tracking" sheet. The document directed staff to check the exit and bedroom door alarms and document the checks daily at 10:00 a.m., 2:00 p.m. and 8:00 p.m. Staff should record a "+" if the alarm worked properly and a "-" if the alarm malfunctioned. In the event the alarm failed to function, staff should contact supervisory staff immediately. The sheet lacked documentation of alarm checks on 10/20/16 at 10:00 a.m. and at 2:00 p.m. The 8:00 p.m. checks indicated the exit and bedroom door alarms functioned properly when tested. Additional record review revealed the facility Supervision and Support Procedure. The procedure directed, "1. Staff is required to provide the level of support and supervision that is needed to ensure that individuals supported receive a continuous active habilitation program that consists of interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual's program plan. 2. If an individual's program plan does not specifically outline the frequency that staff is to provide active habilitation and supervision, they will follow the general guidelines of engaging and supervision each individual at a minimum of every 30 minutes." Additionally, the procedure noted: "5. Staff is required to provide whatever assistance and supports individuals need at any time during their shift and throughout the night." Record review on 10/26/16 revealed Client #2's IPP to reduce acts of elopement. The program directed staff to check on Client #2 every 5 minutes if/when he/she attempted to elope. The IPP failed to define his/her level of supervision.	W 104		

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W 104	Continued From page 5 2. Observation on 10/25/16 at 11:00 a.m. revealed Client #1 sat in a recliner at the day program with a keyboard across his/her lap. When interviewed he/she stated he/she slept all night except to get up and go the bathroom. When asked if he/she ever went for a walk at night Client #1 stated he/she went once and the alarm went off and "they caught me." Observation at the home on 10/25/16 at 11:30 a.m., revealed a chime sounded when the surveyor entered the inside door of the home. Program Coordinator (PC) A explained the facility recently added the chime to all exit doors because they can't be disarmed and they sound whenever someone goes in or out an exit door. She further explained the facility added keyed alarms to all exit doors and Client #1's bedroom door following an incident of elopement by Client #1 in June. She noted staff turn the keyed alarms off when no clients are in the building. Observation of Client #1's bedroom door on 10/25/16 at 11:45 a.m. revealed a white box alarm located on the top of the bedroom door near the hinge. The alarm included a switch and the words "instant" and "delay". PC A opened the bedroom door and no alarm sounded. She stated Client #1 knew how to delay the alarm. She noted staff don't use the delay and only key the alarm on when Client #1 is ready to go to bed at night. Further observation revealed a bathroom across the hall from Client #1's bedroom, approximately 6 steps from the west exit door. Further observation revealed the same white keyed alarm boxes on the west exit door, the inside entry door and the kitchen door.	W 104		

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W 104	Continued From page 6 Observation of the facility and surrounding area on 10/25/16 at 11:00 p.m. revealed a paved driveway at the facility leading to a paved Dairy Queen (DQ) parking lot. According to the odometer on the surveyor's vehicle, the west door of the facility was approximately one tenth of a mile from the DQ parking lot. The surveyor drove to the gas station adjacent to the DQ and the odometer indicated another tenth of a mile. A light pole at the end of the paved road leading from the facility and DQ parking lot to the blacktop road (County Road M16) provided some light on the DQ parking lot but no other signs or lights illuminated the parking lot. Between 11:00 p.m. and 11:15 p.m., three vehicles drove down the paved blacktop. The posted speed limit was 35 miles per hour (mph). No vehicles drove in the DQ parking lot. One car exited the gas station lot via a separate driveway. The gas station parking lot was illuminated by a tall Shell neon sign and by lights all around the pumps. Both the gas station and the DQ were closed during the observation. 3. When interviewed on 10/25/16 at 11:50 a.m. DSP A confirmed he watched television with Client #1 on 10/20/16 at approximately 11:30 p.m. He recalled he watched Client #1 walk down the hall and enter the bathroom. He stated he used the restroom up the hall himself. When he exited the restroom he noted the door of the bathroom Client #1 entered was still closed and he saw light from the bottom of the door. DSP A assumed Client #1 remained in the bathroom. He said he returned to the kitchen to make lunch for the next day. He noted he went down the hall at 12:00 a.m. to do room checks and saw Client #1's bedroom door closed. Upon entering the bedroom, he discovered Client #1's absence.	W 104		

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W 104	Continued From page 7 DSP A confirmed the bedroom door alarm was not on and explained staff turn it on after Client #1 chooses to go to bed because he/she stays up and goes in and out of the bedroom frequently. He stated he checked the bathroom and all other rooms and realized Client #1 eloped. DSP A said he left the building to have a cigarette at approximately 11:00 p.m. and turned the west exit door alarm back on when he came back into the building. When re-interviewed on 10/25/16 at 12:10 p.m., DSP A confirmed Client #1 made attempts to leave the building on the overnight shift prior to 10/20/16. He said he conducted regular room checks every half hour and referred to the bed check sheet. He stated DSP B found Client #1 in the parking lot between the DQ and the gas station located approximately one tenth of a mile from the facility. He recalled he found a paper clip on the ground outside the exit door and presumed Client #1 used the paper clip to deactivate the keyed alarm on the west exit door. He again noted the bedroom door alarm was off because Client #1 sat in the living room and staff only turned it on when he/she went to bed for the night. DSP A stated Client #1 wore black or blue jogging pants, a black tee shirt and brown tennis shoes. He confirmed he/she returned wearing the same clothing and no jacket or coat. He recalled the weather that night was "chilly". He further noted Client #1 wore glasses and hearing aids but wore neither when he eloped between 11:45 p.m. and 12:00 a.m. on 10/20/16. He reiterated he turned the alarm back on after he smoked and couldn't explain how Client #1 eloped without the alarm sounding. DSP A stated he didn't think Client #1 could safely cross the street.	W 104		

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W 104	Continued From page 8 When interviewed on 10/25/16 at 12:50 p.m., DSP B confirmed she received a call from DSP A on 10/20/16 and drove to the facility. She noted she drove to the gas station first because she knew Client #1 liked to go there and get car magazines. She confirmed she found Client #1 looking in the window of the drive thru at the DQ located west of the facility. She recalled she called his/her name and he/she jumped up on a flatbed trailer parked in the parking lot. She said she got out of her van and walked to Client #1, gently touched his/her arm and told him/her it was time to go home. Client #1 got in her van and she drove up the paved driveway to the facility without incident. DSP B stated Client #1 made multiple attempts to leave the facility in October, but staff observed him/her and directed him/her back to the home. She noted he/she ran fast when he/she eloped and would run out whatever door he/she was near. She confirmed Client #1 returned to the facility and went into his/her bedroom. She stated she and DSP A turned the bedroom door alarm on before she left the home. DSP B confirmed Client #1 was not wearing his/her glasses or hearing aids when she found him. She recalled the weather was "chilly" and she turned the heater on in the van as they drove to the facility. She said Client #1 wore tennis shoes, wind pants, a blue shirt and a baseball hat. DSP B stated the alarm on Client #1's bedroom door was off when she left the facility at 10:00 p.m. on 10/20/16. She explained staff turn the alarm on when Client #1 went to bed for the night. She recalled he/she sat in the living room watching television when she left. She further noted the alarms on all doors worked correctly when she did the 8:00 p.m. checks. She answered, "I don't think so" when asked if Client	W 104		

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W 104	Continued From page 9 #1 could safely cross the street. DSP B stated the area was "quite dark" and she saw Client #1 when her headlights shone on him/her. She didn't see any other cars enter or leave the parking lot. She presumed Client #1 turned the door alarm to delay to disarm it when he/she left the building; though she stated DSP A told her he found a paperclip near the door and assumed Client #1 used it to disarm the alarm. When interviewed on 10/25/15 at 1:40 p.m., the Program Director stated she assumed the alarm failed to function on 10/20/16 when Client #1 left the building because staff failed to turn the alarm back on. She stated awareness of staff disarming the when Client #1 came out of his/her bedroom and said staff should turn it back on each time he/she entered the bedroom. She confirmed staff were allowed to go outside to smoke and are expected to turn the alarm back on when they re-enter the home. When interviewed on 10/25/16 at 3:20 p.m. , DSP C confirmed Client #1 attempted to elope the weekend prior to the incident. She recalled he/she ran out the west exit door. She noted Client #1 went to his/her bedroom due to visitors being loud in the living room, then came out and left via the west door. She stated she ran after him/her and directed him/her back to the home. She noted the alarm on the bedroom door is shut off during the day on the weekends she worked. When interviewed on 10/25/16 at 4:30 p.m., the State Climatologist said the temperature in the area of the home was 36 degrees , the wind was calm and the sky was clear on 10/20/16 between 11:30 p.m. and 12:30 a.m. on 10/21/16.	W 104		

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W 104	Continued From page 10 4. Record review on 10/26/16 revealed an Incident Investigation Overview completed by the Area Director on 10/25/16. Her summary of the incident noted, "On 10/20/16 at approximately 11:45 p.m. (Client #1), individual receiving services, had an unobserved elopement, walking to the Shell gas station, located south of the REM Iowa campus. On duty staff (DSP A) called (DSP B) to assist with locating (Client #1). (DSP B) found (Client #1) at approximately 12:28 a.m. and returned (him/her) to the home. A physical assessment was completed on 10/21/16 by program nurse, no new injuries noted." Conclusions noted in the investigation included: a. Client #1 eloped from the facility between 11:45 p.m. (10/20/16) and 12:00 a.m. (10/21/16) to go to the Shell gas station. b. Staff first noticed Client #1 missing at 12:00 a.m. on 10/21/16. c. Staff returned Client #1 to the home at approximately 12:28 a.m. on 10/21/16. d. Client #1 wore long sweat pants, short-sleeved tee shirt, a baseball cap and tennis shoes during the elopement. e. A physical assessment completed on 10/21/16 indicated no new injuries. f. Client #1 had a history of elopement with an IPP in place to address the behavior. The last unobserved elopement occurred on 6/2/16. g. DSP A reported he went outside the hallway door (west) to smoke around 11:30 p.m. and shut the alarm off when exiting the building but immediately turned it back on when he re-entered the home. He maintained all the alarms were on and functioning during his shift on 10/20/16. DSP A maintained Client #1 manipulated the door alarm "somehow" to prevent the hallway door alarm from sounding.	W 104		

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W 104	Continued From page 11 When interviewed on 10/26/16 at 10:30 a.m., the Area Director stated staff found flyers from the gas station on Client #1's bed on 10/21/16. She reasoned he/she walked to the gas station prior to DSP B finding him/her at the DQ. When interviewed on 10/26/16 at 11:21 a.m., the Program Director defined Client #1's level of supervision as "general". She said staff should check on him/her every 5 - 15 minutes during the day and evening shifts. She added, on overnights staff should check clients every half hour. She noted Client #1's level of supervision didn't change after the incident of elopement on 10/20/16. She added staff should know where Client #1 is when he/she is awake. When interviewed on 10/26/16 at 11:48 a.m., DSP D confirmed she checked on Client #1 on the morning of 10/21/16 and saw gasoline receipts laying on his/her bed. She said the Lead DSP collected them and gave them to PC A. When interviewed on 10/26/16 at 12:35 p.m., PC A confirmed she received items from the Lead DSP on 10/21/16. She noted the items received included a ten dollar bill and two one dollar bills, an American Legion membership card, a key card for a business, gasoline receipts and several gas station flyers. She noted Client #1 "collects" things, especially pamphlets and flyers. She confirmed she worked the overnight on 10/16/16 and Client #1 attempted to leave the home. She noted he/she should be in eyesight if awake on the overnight. She added that level of supervision can be difficult when staff check on the other clients. She said "within eyesight" wasn't defined in his/her program. She said she would not work in the kitchen while Client #1 used	W 104		

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(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 104	Continued From page 12 the bathroom, but confirmed nothing existed in writing to give staff this guidance. She stated she didn't think Client #1 would have any awareness of vehicles coming at him/her, especially if he/she lacked glasses and hearing aids. When interviewed on 10/26/16 at 1:05 p.m., DSP E confirmed Client #1 left the facility through the west door during her shift on 10/8/16. She said she redirected him/her back into the building. She recalled he/she ran out the door and down the gravel part of the driveway and estimated the distance to be approximately 15 feet. She said she checked on him/her "a lot" and went to check on Client #1 whenever she heard an alarm sound. She added she'd seen him/her reach up to touch the alarm on the entry way door. When interviewed on 10/26/16 at 1:35 p.m., PC B confirmed she received a call from DSP A at approximately 12:05 a.m. on 10/21/16 to report Client #1 eloped. She recalled DSP A said the alarms were on but failed to go off when Client #1 left the building. She noted awareness of Client #1's history of elopement. When interviewed on 10/26/16 at 1:47 p.m., DSP F confirmed Client #1 left the building on 10/1/16 through the west door. She said DSP C followed him/her and they returned to the building. She described his/her level of supervision as 24 hour care and said she checked on Client #1 every hour when he/she stayed in his/her bedroom. She noted she turned the alarm on whenever he/she remained in the bedroom. She said she turned the alarm off if Client #1 came out and sat in the living room. When interviewed on 10/26/16 at 2:04 p.m., DSP	W 104		

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	16G052	A. BUILDING _____ B. WING _____	C 10/27/2016

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REM IOWA-BIRCH COTTAGE	29 EAST STREET SHELBY, IA 51570

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W 104	Continued From page 13 G confirmed he worked the overnight shift at the house next door to Client #1's house on 10/20/16. He recalled DSP A called and said Client #1 left the house and the alarm didn't sound. He said DSP A asked him to look around the house and premises and DSP G did as asked. He noted DSP A called him several times but within half an hour from the first call, he received a call that DSP B found Client #1. He stated Client #1 would not have crossed the county road to get to the gas station but would have crossed the parking lot of the DQ. DSP G added he wore a light jacket when he went outside to look for Client #1 because the temperature had dropped a little. When re-interviewed on 10/26/16 at 2:20 p.m., DSP B confirmed she documented two attempted elopements by Client #1 on 10/17/16. She said one attempt included use of the front (entry) door and the other attempt was out the west door. She confirmed the alarms on each door sounded at the time of the attempted elopements. She confirmed she found Client #1 in the driveway of the DQ and denied he held any documents (receipts, money, etc) at the time. She further denied seeing him on the county road at any time. When interviewed on 10/26/16 at 2:40 p.m., DSP C confirmed she followed Client #1 out the west door and directed him/her back inside on 10/18/16. She confirmed the west door alarm sounded, but stated the bedroom door alarm was not on even though Client #1 had entered his/her bedroom. She defined Client #1's level of supervision as constant. She activated the bedroom alarm only when he/she went to bed. She noted she didn't turn the alarm on right away because sometimes Client #1 went to bed and	W 104		

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REM IOWA-BIRCH COTTAGE	29 EAST STREET SHELBY, IA 51570

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W 104	Continued From page 14 then got up within 10 minutes. She said the alarm is loud and annoys his/her housemates. When interviewed on 10/26/16 at 4:07 p.m., the Lead DSP confirmed she found money, receipts a key card (type used to enter a building) and pamphlets from the gas station on Client #1's bed on 10/21/16. She confirmed she gave them to PC A. She noted she checked on Client #1 because he/she had gone to his/her bedroom and she had heard about an incident of elopement earlier that morning. She said the bedroom door alarm was turned on. She asked Client #1 where the items came from and he/she told her from someone's car. She said Client #1's level of supervision was 1:1 with eyes on him/her at all times. She noted difficulty in maintaining his/her supervision when only two staff are on duty. She further noted Client #1's elopement behavior increased recently. She said she understood staff should check on him/her every 10 minutes but nothing was "set in stone". She said she had seen Client #1 try to take the alarm off his/her bedroom door and she also saw him try to put a piece of a broken CD into the key slot to disarm the alarm. 5. When interviewed on 10/27/16 at 8:50 a.m., the Program Director confirmed the facility failed to define Client #1's supervision level to guide staff to ensure his/her safety. She stated the bedroom door alarm should remain on whenever he/she entered the bedroom unless staff accompanied him. At 10:10 a.m., the Program Director said PC A should check the alarm sheets when she conducts the monthly audits. She confirmed the facility had no written policy defining levels of supervision (e.g. general, eyesight, etc.). She further confirmed Client #2's	W 104		

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REM IOWA-BIRCH COTTAGE	29 EAST STREET SHELBY, IA 51570

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W 104	Continued From page 15 IPP contained no guidance to staff regarding level of supervision. In summary, the facility failed to provide direction to staff regarding individual supervision levels based on needs. In addition staff failed to consistently check alarms and turn alarms on to ensure client safety. On 10/26/16 at 10:58 a.m., an Immediate Jeopardy (IJ) was identified based on the facility failures. The facility was notified at 11:20 a.m. The facility developed and implemented a plan of abatement to provided an enhanced level of supervision and to assure staff re-training and monitoring. The IJ was abated on 10/27/16 at 1:05 p.m.	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. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to inform a client's guardian of the use of psychotropic (behavior modifying) medications. This affected 1 of 1 client during the investigation of incident #63854-I (Client #1). Findings follow: Record review on 10/26/16 revealed Client #1's Informed Consent signed by the guardian on 8/19/16. The document listed the following behavior modifying medications and ranges: Lithium (range 300 -1800 milligrams (mg) Atarox (range 100 - 300 mg) Clonazepam (0 - 450 mg)	W 125		

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W 125	Continued From page 16 Zyprexa (range 10 - 40 mg) Further record review revealed Client #1's Physician's Orders signed on 9/16/16. The orders included administration of the medications Divalproex, 1750 mg a day, and Fluvoxamine 200 mg a day. The document included no order for Atarox. When interviewed on 10/26/26 at 11:40 a.m., the Registered Nurse (RN) stated after a recent hospitalization, the doctor discontinued the medication Atarox. She confirmed the orders reflected the medications Client #1 currently received. When interviewed on 10/26/16, the Program Director confirmed the informed consent failed to include Divalproex and Fluvoxamine. She noted Client #1 received the medications due to behaviors.	W 125		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure each Individual Program Plan (IPP) specified client supervision levels to maintain client safety. This affected 2 client during the investigation of incident #63854-I (Client #1 & Client #2). Findings follow: Record review on 10/25/16 revealed Client #1's Individual Incident Report. The report documented Client #1's elopement from the	W 234		

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W 234	Continued From page 17 facility on 10/20/16. The report written by Direct Support Professional (DSP) A noted he conducted routine bedroom checks at 12:00 a.m. on 10/21/16 and discovered Client #1 was not in his/her room. DSP A searched the house and found the door at the west end of the building partially open. He noted the alarm on the door failed to sound prior to the discovery of Client #1's absence. DSP A notified the appropriate personnel for assistance. The incident report noted DSP B found Client #1 near a gas station and returned him/her to the facility. Further record review revealed Client #1's Individual Program Plan (IPP) to reduce acts of elopement. Identified behaviors included threatening to elope, observed elopement (defined as leaving the facility grounds with staff knowledge) and unobserved elopement (defined as leaving the facility without staff knowledge). Restrictive measures included use of a physical escort to direct Client #1 to a safe area, behavior modifying medications and use of alarms on all exit doors in the home and on Client #1's bedroom door. The IPP directed staff to check on Client #1 every 5 minutes when he/she attempted to elope. The IPP contained no other direction regarding supervision or use of the alarms on Client #1's bedroom door or exit doors. Interviews with staff on 10/25/16 revealed the following: a. At 11:50 a.m., DSP A confirmed he worked in the kitchen of the home while Client #1 used the bathroom on 10/20/16 at approximately 11:45 p.m. He confirmed he failed to activate the alarm on Client #1's bedroom door because Client #1 remained awake and he/she went in and out of	W 234		

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W 234	Continued From page 18 the room frequently. He noted he conducted regular bed checks of all residents at half hour intervals. b. At 12:50 p.m., DSP B confirmed staff turned the bedroom door alarm off when Client #1 wasn't in the bedroom. c. At 1:40 p.m., the Program Director stated staff should turn the bedroom alarm on each time Client #1 entered the bedroom. d. At 3:20 p.m., DSP C stated the alarm on Client #1's bedroom door remained off during the day despite his/her repeated use of the door. Continued staff interviews on 10/26/16 revealed: e. At 8:58 a.m., the Program Director confirmed one staff worked the overnight shift and couldn't leave to follow Client #1 if staff observed him/her exiting the building. She confirmed by definition in the IPP, an observed elopement would become an unobserved elopement because of a lack of supervision. f. At 11:21 a.m., the Program Director defined Client #1's level of supervision as "general". She stated staff should check on him/her every 5 -15 minutes during the day and evening and every 30 minutes on the overnight. She then stated staff should know Client #1's location while awake. g. At 12:35 p.m., Program Coordinator (PC) A stated Client #1 should be in eyesight of staff if awake on the overnight. She confirmed the IPP failed to include this information. h. At 1:05 p.m., DSP E confirmed Client #1's	W 234		

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W 234	Continued From page 19 elopement behavior. She said she checked on him/her "a lot" and whenever she heard an alarm. i. At 1:47 p.m., DSP F stated Client #1 required 24 hour supervision and noted she checked on him/her every hour if he/she went to the bedroom. She said the alarm remained off when Client #1 sat in the living room. j. At 2:40 p.m., DSP C defined Client #1's level of supervision as constant. She noted the bedroom door alarm remained off until he/she went to bed. She noted she waited for approximately 10 minutes before turning the alarm on because Client #1 may come back out of the bedroom. k. At 4:07 p.m., the Lead DSP said Client #1's level of supervision was 1:1 with eyes on him/her at all times. She stated staff should check on him/her at least every 10 minutes but noted this directive was not written in the IPP or "set in stone". When interviewed on 10/27/16 at 8:50 a.m., the Program Director confirmed the facility failed to specify Client #1's level of supervision in the IPP to ensure his/her safety throughout all shifts. 2. Record review on 10/26/16 revealed Client #2's IPP to reduce acts of elopement. The program directed staff to check on Client #2 every 5 minutes if/when he/she attempted to elope. The program failed to define his/her level of supervision. When interviewed on 10/27/16 at 10:10 a.m., the Program Director acknowledged Client #2's IPP lacked information specifying his/her level of supervision.	W 234		

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W 234	Continued From page 20 In summary, the facility failed to ensure the IPPs specified the supervision level clients needed to maintain their safety through out all shifts. In addition, the use of the alarm on Client #1's bedroom door lacked clarity and specificity for activation/de-activation. On 10/26/16 at 10:58 a.m., an Immediate Jeopardy (IJ) was identified based on facility failures. The facility was notified at 11:20 a.m. The facility developed and implemented a plan of abatement to provide an enhanced level of supervision and to assure staff re-training and monitoring. The IJ was abated on 10/27/16 at 1:05 p.m.	W 234		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all Individual Program Plans (IPP) included all restrictive measures. This affected 1 of 1 client during the investigation of incident #63854-I (Client #1). Findings follow: Record review on 10/25/16 revealed Client #1's IPP to reduce acts of elopement revised on 10/24/16. Restrictive measures in the IPP included use of behavior modifying medications including Hydroxine, Abilify and Lithium.	W 289		

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W 289	Continued From page 21 Record review on 10/26/16 revealed Clients #1's Physician's Orders signed on 9/16/16. The orders included the use of Lithium but not Hyrdroxine or Abilify. In addition, the signed orders included use of the medications Divalproex, Fluvoxamine, Zyprexa and Clonazepam. When interviewed on 10/27/16 at 11:15 a.m., Program Coordinator (PC) A confirmed the program failed to identify the medications Divalproex, Fluvoxamine, Zyprexa and Clonazepam.	W 289		

✓ RK 12/18/16

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

W102: Facility Response:
The facility Program Coordinator/QIDP, Lead Direct Support Professionals (DSPs), and Program Director/QIDP will work together to ensure that individuals are receiving appropriate supervision and that there are clear and specific directions for DSPs to follow regarding individual supervision. Programming was updated to include how staff should supervise individuals with elopement risk to ensure that staff is aware of his whereabouts at all times during a shift. DSPs were trained on the programmatic, supervision and increased staff communication changes. Specific changes and supervision levels were also increased on the overnight shift. Should this individual's sleep patterns return to a more normal schedule where he is sleeping consistently, this level of staffing on the overnight shift will be re-evaluated by REM leadership to determine if it remains necessary to ensure this individuals supervision and safety. DSPs will continue to receive on-going training regarding levels of supervision and any changes that may occur regarding this. These topics may be reviewed during monthly staff meetings, annual Plan of Care meetings and/or informally as changes or concerns arise.

Correction Date: 11/18/16

W104: Facility Response:
The facility Program Coordinator/QIDP, Lead DSP, and Program Director/QIDP will ensure that elopement programs are reviewed and revisions are evaluated to ensure they include clear and specific directions regarding individual supervision and safety. This will include training on checking facility door alarms, conducting and documenting bed checks, and providing supervision to individuals who wake up during the overnight hours. Cross reference response to W102.

Correction Date: 11/18/16

W125: Facility Response:
The facility Program Coordinator/QIDP, Lead DSP, and Program Director/QIDP will ensure that consent is obtained from individual's guardians as well as the Human Rights Committee (HRC) members before any new medications are implemented or if there are changes to medications outside of the approved ranges that have been consented to. Restrictive measures and psychotropic medications will be reviewed and evaluated on a quarterly basis during HRC meetings and annually at the time of the Plan of Care meeting. Any changes

made to medications that fall outside the approved medication dose range will be communicated to the guardian and HRC to receive verbal approval before it is implemented.

Correction Date: 12/18/16

W234: Facility Response:
The facility Program Coordinator/QIDP and/or Program Director/QIDP will ensure that elopement programs are reviewed and revisions are evaluated to ensure they include clear and specific directions regarding individual supervision and safety. This will include training on checking facility door alarms, conducting and documenting bed checks, and providing supervision to individuals who may wake up during the overnight hours. Staff will receive on-going training on this as well as formal training when programs are revised. These topics may be reviewed during monthly staff meetings, annual Plan of Care meetings and/or informally as changes or concerns arise. Cross reference response to W102.

Correction Date: 11/18/16

W289: Facility Response:
The facility Program Coordinator/QIDP, Lead DSP, and Program Director/QIDP will ensure that interventions used to manage inappropriate client behavior are incorporated in to the Individual Program Plan (IPP). This includes all restrictive measures and psychotropic medications that may be used. The IPP cited in the citation has been revised accordingly. IPPs are reviewed monthly during data summary completion and changes/revisions may be made throughout the year as necessary. IPPs are also evaluated and/or revised at the time of the annual Plan of Care meeting.

Correction Date: 12/18/16
