KL 2/2/17 CAC 2/2/17

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

PRINTED: 02/03/2017
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
	16G033	A. BUILDING _____ B. WING _____	C 01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-36TH AVENUE	29 36TH AVENUE S W CEDAR RAPIDS, IA 52404

(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 Investigaiton 65007-I a deficiency was cited at W104.	W 000	See attached POC 2/3/17	
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 observation, interviews and record review, the facility's governing body failed to ensure staff followed established facility policy and the facility policy provided appropriate direction to ensure the safety of clients. This affected 1 of 1 client (Client #1) involved in investigation 65007-I. Finding follows: Client #1's Incident Report (IR) documented on 1/6/17 revealed the Program Coordinator (PC) found the client sitting alone in the facility van at approximately 3:45 p.m. No staff were in the immediate area and did not have eyes on the client from within the house. Upon entering the facility with the client, the PC talked with Direct Support Professional/Certified Medication Aide (DSP/CMA) A, who was unaware the client had not entered the facility after returning from the day program. The PC also talked with DSP B and DSP C who were also unaware the client had not entered the facility. DSP C informed the PC she assisted Client #1 off the van but did not formally escort the client into the facility. The IR documented staff admitted the situation was not one staff's fault because all staff were responsible for the safety of the clients. The PC also documented he completed an informal	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Regional Director 02/13/17

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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W 104	Continued From page 1 assessment on Client #1 and did not observe any signs of injury or frostbite. The PC documented he discussed with staff they were to ensure all individuals were accounted for by providing head counts and to focus on all individuals and not just those they were assigned to. Client #1's diagnosis included Severe Intellectual Disability, Impulse Control Disorder, Intermittent Explosive Disorder, Seizure Disorder, Leukopenia, Gastro-esophageal Reflux Disorder, Ceruminosis, and Early Periodontal Disease. Client #1's Plan of Care (POC), dated 8/12/16, documented the client had a history of elopement and required supervision from staff when out in the community or in the front or back yard of the facility. When inside the facility, door alarms should be engaged to alert staff if Client #1 left the facility into either yard. Client #1's Individual Program Plan (IPP) addressing elopement documented Client #1 should be in eyesight at all times while in the community. Client #1's Nurses Notes on 1/6/17 at 1645 documented a physical assessment was completed with vitals as follows: Body Temperature - 97.6, Pulse-74, Respiration-11, Blood Pressure-105/71 and Oxygen at 99%. Heart and lung sounds were normal and skin was dry. Client #1 appeared to functioning at baseline with no indication of pain or discomfort. Observation of Client #1 at RDS on 1/11/17 revealed the client sat at a table with staff watching a marching band video on an IPad. Staff had a timer close by and when the timer	W 104		

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W 104	Continued From page 2 went off she changed the activity and they played Connect 4. During the observation the client did not vocalize or verbalize any words. Staff showed the surveyor the IPad application offering a variety of phrases familiar to the client to enhance his/her communication. Accuweather documented the high for 1/6/17 was 8 degrees Fahrenheit (F) and low of -5 degrees (F). When interviewed on 1/10/17 at 10:15 a.m. the PC stated he arrived at the facility at approximately 3:45 p.m. and observed Client #1 sitting in the front seat of the facility van. He assisted the client out of the van after observing no staff were present outside the facility. Client #1 walked toward his personal vehicle and had to be redirected toward the entrance of the facility. The PC stated he unlocked the gate and walked with the client into the facility. He stated he immediately questioned the three staff on-duty and determined they did not realize the client had not come into the facility after returning from the day program. DSP C told the PC she had assisted the client off the van and observed him/her walking toward the facility entrance. The PC stated the client could not have come into the facility and walked out again because he/she would not have been able to open the gate once it was latched. He notified his supervisor and also talked with the Quality Improvement Specialist (QIS). Nursing was also notified to complete an assessment. The PC stated he informally completed an assessment on the client and found no injuries or signs of frostbite. He stated he did remind staff they should always know clients' whereabouts through the use of a head count or checking on clients. He stated the client had	W 104		

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W 104	Continued From page 3 never done anything like this before. When interviewed on 1/10/17 at 10:50 a.m., the QIS stated the PC had notified her on 1/6/17 regarding the client being left on the facility vehicle. She initiated an investigation and to date had completed most of the staff interviews. She was able to determine a phone call had been made to the facility by the Registered Nurse (RN) at 3:18 p.m. and staff/clients were present in the facility. The QIS stated CMA C had assisted Client #1 off the van and then became distracted by other duties such as helping another client off the van and observing a client retrieve the mail. She stated staff did not walk into the facility with Client #1 but assumed the client came into the facility after being assisted off the van. When interviewed on 1/10/17 at 10:45 a.m., the Licensed Practical Nurse (LPN) was contacted on 1/6/17 to complete an assessment on Client #1 due to being left on the facility vehicle. She completed the assessment between 4:30-4:45 p.m. and found no apparent injuries. The client's vitals were normal and body temperature was normal. She found Client #1 in good spirits and was cooperative with the exam except he/she would not let her touch his/her toes. When interviewed on 1/10/17 at 11:45 a.m., the RN stated on 1/6/17 she contacted the facility at approximately 3:10 p.m. by phone to talk to staff but was unable to reach anyone. She tried again at 3:18 p.m. and talked with DSP/CMA A about medication changes and the PC would be bringing a revised Medication Administration Record to the house for her. When interviewed on 1/10/17 at 2:20 p.m., DSP	W 104		

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W 104	Continued From page 4	W 104		

C stated on 1/6/17 they picked all the clients up at REM Developmental Services (RDS). When they arrived at the facility the driver (DSP B) got off the van and went inside the facility with a couple of clients. DSP/CMA A then took a couple of clients inside the facility. DSP C then assisted Client #1 off the van. She observed as the client walked toward the entrance of the facility. She then stepped inside the van to unbuckle the seatbelt of the last client on the van. After watching a client retrieve the mail, DSP C walked inside toward the front door and latched the gate. She went immediately to the laundry room to changeover laundry. DSP C stated she was still in the laundry room when she was approached by the PC approximately 10 minutes after arriving at the facility. He questioned whether she knew Client #1 had been left on the van. DSP C informed the PC she had assisted the client off the van and observed him/her head in the direction of the facility but was unaware the client had gotten on the van again. Since she turned her attention to the remaining client on the van and the client retrieving mail, DSP C thought Client #1 must have walked around the van, and got into the front seat of the van after she had walked inside. DSP C stated she had been trained to do a head count when clients get on the van but had not thought about doing a head count once they returned to the facility. She stated Client #1 did not have any inappropriate behaviors on the van and did not have any issues following the incident. She stated normally Client #1 would go to his/her bedroom or the living room after returning from RDS until snack time.

When interviewed on 1/10/17 at 2:35 p.m. DSP B stated they had a normal day picking everyone up from RDS on 1/6/17. She was driving the van

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W 104	Continued From page 5 and when they arrived at the facility she turned the ignition off and walked into the house with two clients. She went with the clients because she had to unlock the door. DSP B stated she went immediately into the kitchen and set out items for snack and began supper preparations. She thought it was approximately 10-15 later the PC came to the facility and asked if she was aware Client #1 had been left on the van. DSP B stated she was unaware of the situation. DSP B stated they generally do a head count when they are on the van but do not do one when clients return home because staff usually follow them in the facility. She stated staff should know the whereabouts of clients at all the time. When interviewed on 1/10/17 at 2:45 p.m. DSP/CMA A stated she assisted in picking up clients at RDS on 1/6/17. Upon return to the facility, DSP B went into the house first assisting two clients. She followed, assisting other clients while DSP C remained outside assisting the remainder of the clients. Upon her return, DSP/CMA A stated she received a telephone call from the RN about some medication changes. She was aware the PC would be bringing a new Medication Administration Record to the facility. Following the phone call, she visited with a client in the dining room, discussing a family problem they were having. She thought it was about 10 minutes after they returned to the facility, when the PC arrived. He asked if anyone knew Client #1 was still on the van. DSP/CMA stated she was unaware the client was in the van and had not come into the facility. She stated the client had sat in the third row of seating on the way home from RDS but understood the PC had found him/her in the front seat of the van. Client #1 required assistance to get off the van due to	W 104		

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W 104	Continued From page 6 unsteadiness so staff always have to help the client step out of the van. The client would be able to open the van door but could not manipulate the gate latches independently. DSP/CMA A stated generally she was the last staff in the house and checked the gate lock and the alarm on the front door. Since she had to pass medication and received a phone call upon her routine, she went into the facility while some clients were still on the van with DSP C. She stated they do a head count on the van prior to leaving RDS but do not normally do one when they return to the facility. DSP/CMA stated staff should know the clients ' whereabouts and all staff should have ensured Client #1 came into the facility. Record review on 1/10/17 revealed the facility procedure entitled "Supervision and Support." The procedure included if the client's IPP did not include the frequency of staff supervision, staff should follow general guidelines of engagement and supervision at a minimum of every 30 minutes. The policy also noted "Under no circumstances are individuals to be left unsupervised unless otherwise indicated in the individual's plan of care." A policy addressing Community Integration and Safety Protocols also noted prior to loading vehicles employees would ensure all clients participating were accounted for by completing a head count. No information in the policies included direction to staff regarding accountability of clients when returning from outings/day program. When interviewed on 1/10/17 at 9:45 a.m. the Program Director (PD) confirmed staff should have followed the Supervision and Support Policy. She also stated staff had been trained to	W 104		

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W 104	Continued From page 7 complete head counts but the policy did not specifically address when clients returned to the facility. She also stated staff had been trained to ensure they know the whereabouts of clients at all times. At 2:00 p.m., the PD stated the policy addressing supervision and supports had been revised to include a head count when the clients returned to the facility from day program or outings and immediate training would be completed. Also, staff would be retrained on the Community Integration and Safety Protocols policy. She stated this even though this policy also had information regarding the completion of head counts; she wanted to review it with staff.	W 104		

VLK 2/22/17 CAC 2/21/17

Accept this plan as the facilities credible allegation of compliance.

Tag W 104: **Facility Response:** The Program Director/QIDP updated the Supervision & Support procedure to include a specific directive to complete head counts upon arrival at a destination. The Program Coordinator provided formal feedback to the facility staff working during the incident on 1/6/17. The Program Director/QIDP, Program Coordinator or designee retrained all staff on the Supervision & Support Procedure and Community Integration and Safety Protocols Procedure. Going forward, the Program Director/QIDP, Program Coordinator or designee will ensure all staff review the Supervision & Support Procedure and Community Integration and Safety Protocols Procedure on an annual basis. The Program Director/QIDP, Program Coordinator and/or designee will review incident reports upon completion to ensure ongoing compliance. Immediate and specific feedback and training will occur as needed going forward.

Completion Date: 2/3/17