

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

PRINTED: 03/08/2017
FORM APPROVED
OMB NO. 0938-0391

1/11
3/29/17
C/C
3/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CMS IDENTIFICATION NUMBER: 186082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2017
NAME OF PROVIDER OR SUPPLIER REM IOWA-BIRCH COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 20 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	<p>INITIAL COMMENTS</p> <p>The investigation of #68108-I was conducted 2/21 - 2/22/17. The investigation resulted in a determination of immediate jeopardy (IJ), due to concerns with client safety. The facility was notified of the IJ on 2/22/17 at 9:45 a.m.. The facility provided a plan, which included increased supervision for Client #1. The IJ was removed on 2/22/17 at approximately 12:15 p.m.</p> <p>The Condition of Participation (CoP) - Governing Body (W102) was cited.</p> <p>Standard-level deficiencies were cited at W104 and W249.</p>	W 000	<p>please see attached</p> <p><i>PDC 3/8/17</i></p>	
W 102	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain minimal compliance with Condition of Participation (CoP) Governing Body and Management. The governing body failed to monitor overall services and adequately provide operating direction to effectively ensure individuals received appropriate supervision, services and supports. Additionally, the governing body failed to ensure consistent supervision of an environment to safeguard and protect the safety of individuals served.</p> <p>Cross reference W104: Based on observations,</p>	W 102		

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DD

3/13/17

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 16G082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2017
NAME OF PROVIDER OR SUPPLIER REMI IOWA-BIRCH COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 20 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 102	<p>Continued From page 1</p> <p>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.</p> <p>Cross reference W249: Based on interview and record review, the facility failed to consistently ensure a client behavior support program was implemented by staff.</p>	W 102		
W 104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observations, 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. The findings constitute an immediate jeopardy to the resident's health and safety. This affected 1 of 1 client involved in the investigation of #88108-I (Client #1). Finding follows:</p> <p>Record review on 2/21/17 revealed a facility investigation detailing Client #1's elopement from the facility on the evening of 2/05/17. Staff estimated they last heard Client #1's voice around 9:15 p.m. and noticed him/her missing around 9:20 p.m. The facility received a phone call from the Sheriff's Department at 9:29 p.m. informing them Client #1 was at the nearby Shell station. Direct Support Professional (DSP) A drove to the nearby gas station and brought Client #1 back to</p>	W 104		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1800352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2017
NAME OF PROVIDER OR SUPPLIER REM IOWA-BIRCH COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 20 EAST STREET SHELBY, IA 51670		
(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	<p>Continued From page 2</p> <p>the facility. Client #1 reportedly left the facility wearing a short sleeved t-shirt, pants, socks and a baseball cap. The client did not wear a coat or shoes. Client #1 had no injuries from the elopement.</p> <p>According to the state Climatologist, the temperature in Harlan, Iowa (approximately 12 miles from Shelby) on 2/05/17 at 9:15 p.m. was 28 degrees with clear skies and winds were calm.</p> <p>Record review revealed Client #1 was 55 years old with diagnoses including: moderate intellectual disability; schizophrenia, chronic paranoid type; depression; dementia; anxiety and hearing loss. Client #1 ambulated independently ambulatory and was verbal, with generally functional communication skills. Client #1 had a history of elopement. He/she eloped on 6/02/16 and 10/20/16. Both of those elopements occurred at night and Client #1 went to a nearby gas station/convenience store.</p> <p>Observation on the morning of 2/21/17 revealed the Shell gas station/convenience store could be seen from the facility. A frontage type of road connected the facility and gas station, at a distance of approximately 2-3 blocks. A person could also cut across and walk to the gas station; it seemed less likely the client would take this route since trees and buildings were in the way. The gas station was next to an off ramp for Interstate 80. A two lane road ran in front of the frontage road. The surveyor walked from the facility to the Shell station at a moderately brisk pace on the morning of 2/21/17 in approximately 3 1/2 minutes.</p> <p>Continued record review revealed Client #1's</p>	W 104		

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NAME OF PROVIDER OR SUPPLIER REM IOWA-BIRCH COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 26 EAST STREET SHELBY, IA 51670		
(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	<p>Continued From page 3</p> <p>behavior program to reduce the incidence of elopement. According to the program, Client #1 was not allowed to leave facility grounds without supervision. Client #1's shoes and hat were placed in the entryway at night to deter elopement during overnight hours. The program indicated if staff were involved in a situation in which they would be unable to know Client #1's whereabouts (for example, assisting other clients) staff would inform Client #1 that he/she needed to go to his/her bedroom and staff would turn on the bedroom door alarm. The elopement program noted alarms on all exit doors at the facility, as well as Client #1's bedroom door. The program read, "Door alarms on facility doors will be on at all times when individuals are in the facility. (Client #1's) bedroom door alarm will be turned on any time (Client #1) is in (his/her) bedroom."</p> <p>Observations on the morning of 2/21/17 revealed the facility had three exits: a front entry/exit (inside door and outside door), a back door off the kitchen and a west door. The front inner door made a chime type of sound whenever the inner door was opened. The chime was turned on at all times and could only be turned off by accessing a locked plastic cover in another room. The door chime was not very loud. The front inner door, the back door and the west door were also alarmed by entering a code in a code box next to the front door and the west door. Staff could turn the alarms off or on at the three exits doors by entering the code at either the front door or the west door. Either of the code boxes controlled the alarms for all three doors. Client #1's bedroom window was also alarmed with the code alarm system used for the three exit doors. In addition, the west door had a very loud alarm that was turned off and on with a key. The west</p>	W 104		

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NAME OF PROVIDER OR SUPPLIER REM IOWA-BIRCH COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 20 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 104	<p>Continued From page 4</p> <p>door was not typically used. Client #1's bedroom door had the same type of key alarm as the west door. The alarm was very loud when it sounded.</p> <p>According to the Pottawattamie County Dispatch, the call from the Shell station on the evening of 2/05/17 came in at 9:23 and 51 seconds p.m. An officer was in route by 9:25 p.m. and arrived at the Shell station by 9:30 p.m.</p> <p>According to the staff schedule provided by the PC on 2/22/17, three staff worked at the facility from 2:00 p.m. to 6:00 p.m. on 2/05/17. Clients were divided into three groups for staff assignments: groups A, B and C. Client #1 was in Group B when three staff were present, but moved to Group A when two staff were present. The staff schedule did not provide clear information on which staff was assigned to which group after 6:00 p.m. on 2/05/17 when staff went from 3 staff to 2 staff. The PC acknowledged this was confusing. The facility provided training sheets that showed DSP A and DSP B had previously been trained on Client #1's elopement program and/or the importance of using the door alarms.</p> <p>Additional record review revealed the facility Supervision and Support Procedure, revised 1/18/17. The procedure directed, "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. If an individual's program plan does not specifically</p>	W 104		

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NAME OF PROVIDER OR SUPPLIER REED IOWA-BIRCH COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 28 EAST STREET SHELBY, IA 51570		
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W 104	<p>Continued From page 5</p> <p>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: "... Staff is required to provide whatever assistance and supports individuals need at any time during their shift and throughout the night..."</p> <p>Further record review revealed "Alarm Inspection Procedure," undated. The procedure instructed, "... The facility door alarms are to be armed at all time when the individuals are in the building... Under no circumstances should the alarm be left off for any extended period of time... Additionally, any time (Client #1) is in (his/her) bedroom, (his/her) door alarm should be on regardless of the amount of time (he/she) is in there or how many times (he/she) leaves (his/her) room for any reason during this time. It is imperative that the alarms always are on and functioning to ensure the safety of (Client #1) due to (his/her) elopement behaviors..."</p> <p>When interviewed on 2/21/17 at 2:10 p.m., Direct Support Professional (DSP) A confirmed she worked at the time of the incident on 2/05/17. DSP A said she turned off the exit door alarms with the code at approximately 8:45 p.m. when DSP C came to the house to pass evening medications. Staff typically turned the alarm back on after staff came in the door, but it was a busy hectic evening and she didn't turn the alarm back on. DSP A said she helped get Client #1 ready for bed and he/she was in bed by 8:45 p.m. with the bedroom door shut. DSP A said she was aware Client #1's bedroom door alarm should have been turned on, but she got busy helping</p>	W 104		

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NAME OF PROVIDER OR SUPPLIER REM IOWA-BIRCH COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 20 EAST STREET SHELDY, IA 51670		
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W 104	<p>Continued From page 6</p> <p>DSP B deal with a client who was aggressive. Client #1 yelled and cursed in his/her room about the other client being aggressive and the noise level. DSP A estimated she last heard Client #1 yelling around 9:15 p.m. DSP A later went to check on Client #1 and saw he/she was not in his/her bedroom. DSP A said she ran to tell DSP B Client #1 was missing and noticed the time on a clock was 9:20 p.m. She and DSP B searched the facility and opened the door to look outside. The sheriff's department called at 9:29 p.m. to tell them Client #1 was at the Shell station. DSP A went to the Shell station and brought the client back to the facility. DSP A said she knew the exit door alarms and Client #1's bedroom door alarm should have been turned on, but she did not recall if she had been trained on Client #1's placement program. She said Client #1 had not threatened to leave the facility. When asked which of the staff were assigned to Client #1 at the time, DSP A said she did not think this was listed on the schedule.</p> <p>When interviewed on 2/12/17 at 1:55 p.m., DSP B confirmed she worked at the time of the incident on 2/05/17. She said DSP C came to the facility from approximately 8:15 p.m. to 8:45 p.m. to pass evening medications. DSP B and DSP A were busy with evening snack and dealing with a behavioral client and they did not turn the exit door alarm back on when DSP C left. DSP B estimated she last heard Client #1 yell from his/her bedroom around 9:15 p.m. DSP A checked on Client #1 between 9:20 p.m. and 9:28 p.m. and saw he/she was not in his/her bedroom. The sheriff's department called at 9:29 p.m. (time showed on the phone) and said Client #1 was at the Shell station. This was just minutes after the staff noticed Client #1 missing. DSP B said she</p>	W 104		

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NAME OF PROVIDER OR SUPPLIER REM IOWA BIRCH COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 20 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 104	<p>Continued From page 7</p> <p>had been trained on Client #1's elopement program and the need to have the door alarms on. She was aware that Client #1 eloped to the Shell station in the past. DSP B said staff usually turned the exit door alarms back on after the medication passer came in, but it was a very chaotic evening, as another client was aggressive and Client #1 and other clients yelled. She said Client #1 had been in his/her bedroom with the door shut, but the staff had been busy with the behavioral client and did not turn on Client #1's bedroom door alarm. DSP B stated Client #1 yelled and cursed from his/her room, but did not threaten to leave. She estimated Client #1 was gone for 1/2 hour or less. DSP B said she did not know which of the two staff was assigned to Client #1 at the time of the elopement.</p> <p>When interviewed on 2/21/17 at 2:25 p.m. DSP C said she came to the facility on 2/05/17 around 8:15 p.m. to pass medications. She rang the bell and DSP A gave her a thumbs up sign through the window to indicate she turned the alarm off. DSP C said she passed client medication and left about 45 minutes later. To her knowledge, the staff had not turned the exit door alarm back on. The alarm did not sound when DSP C left through the front door. She told DSP A and DSP B that she was leaving. DSP C said Client #1 was in his/her bedroom with the door shut when she left. She said DSP A and DSP B were busy dealing with a behavioral client when she left. They were in that client's bedroom.</p> <p>When interviewed on 2/21/17 at 8:25 p.m. the Shell Station Cashier stated she was at the station on the evening of 2/05/17 when Client #1 came in. She said it was a slow night and she was cleaning when Client #1 came in. He/she</p>	W 104		

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NAME OF PROVIDER OR SUPPLIER REM IOWA-BIRCH COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 20 EAST STREET SHELBY, IA 51670	
(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	<p>Continued From page 8</p> <p>asked about magazines and the Cashier told the client the station didn't have any. The Cashier said she did not initially realize the person was mentally disabled. After a couple of comments and questions about magazines, Client #1 suddenly began crying/sobbing. The Cashier then approached Client #1 and noticed he/she was not wearing shoes. The cashier gave Client #1 a glass of water and had him/her sit down and Client #1 wet him/herself at some point. The Cashier said she realized the person had a mental disability and was probably from the facility nearby. She said she assumed someone would come get Client #1. The Cashier estimated Client #1 was at the Shell station for about 15 minutes before she called 911. A sheriff deputy arrived. The Cashier said a staff person showed up for Client #1 about 10 to 15 minutes after she called 911. The Cashier estimated Client #1 was at the Shell station without staff for about 30 minutes.</p> <p>When interviewed on 2/21/17 at 9:25 a.m. the Program Coordinator (PC)/Qualified Intellectual Disability Professional (QIDP) stated two staff were present when Client #1 eloped on the evening of 2/05/17. The PC said the staff were busy dealing with another client's behaviors, who was trying to egress toward a third client. The exit door alarms were not turned on at the time. Staff noticed Client #1 missing around 9:20 p.m. and searched the house and outside. The PC confirmed the door alarms should have been turned on at the time Client #1 eloped. The PC reported when Client #1 eloped in June and October of 2016, he/she went to the same nearby gas station/convenience store.</p> <p>Based on these findings a determination of IJ was</p>	W 104		

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W 104	Continued From page 9 made due to concerns with client safety. The facility was notified on 2/22/17 at 9:45 a.m.. The facility provided a plan, which included increased supervision for Client #1. The IJ was removed on 2/22/17 at approximately 12:15 p.m.	W 104		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure staff implemented a behavior support plan to prevent elopements. Staff on-duty failed to ensure the door alarms were turned on, as directed in the individual program plan. The findings constitute an immediate jeopardy to the resident's health and safety. This affected 1 of 1 client involved in the investigation of #86108-I (Client #1). Finding follows: "Elopement" is defined as a client leaving the facility without staff knowledge or permission. Record review on 2/21/17 of a facility investigation revealed Client #1 eloped from the facility on the evening of 2/05/17 without staff knowledge. Staff estimated they last heard Client #1's voice around 9:15 p.m. and noticed him/her	W 249		

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NAME OF PROVIDER OR SUPPLIER REM IOWA-BIRCH COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 20 EAST STREET SHELBY, IA 51870	
(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 249	<p>Continued From page 10</p> <p>missing around 9:20 p.m. The facility received a phone call from the Sheriff's Department at 9:29 p.m. Informing them Client #1 was at the nearby Shell station. Direct Support Professional (DSP) A drove to the nearby gas station and brought Client #1 back to the facility. Client #1 reportedly left the facility wearing a short sleeved t-shirt, pants, socks and a baseball cap. The client did not wear a coat or shoes. Client #1 had no injuries from the elopement.</p> <p>According to the State Climatologist, the temperature in Harlan, Iowa (approximately 12 miles from Shelby) on 2/05/17 at 9:15 p.m. was 28 degrees with clear skies. Winds were calm.</p> <p>Client #1 was 55 years old with diagnoses including: moderate intellectual disability; schizophrenia, chronic paranoid type; depression; dementia; anxiety and hearing loss. Client #1 ambulated (walked) independently and was verbal, with generally functional communication skills. Client #1 had a history of elopement (8/02/16 and 10/20/16). Both elopements occurred at night and Client #1 went to a nearby gas station/convenience store.</p> <p>Continued record review revealed Client #1's Individual Program Plan (IPP) to address elopement behavior. According to the program, Client #1 was not allowed to leave facility grounds without supervision. Client #1's shoes and hat were placed in the entryway at night to deter elopement during overnight hours. The program indicated if staff were involved in a situation in which they would be unable to know Client #1's whereabouts (for example, assisting other clients) staff would inform Client #1 that he/she needed to go to his/her bedroom and staff would turn on the bedroom door alarm. The elopement program</p>	W 249		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2017
NAME OF PROVIDER OR SUPPLIER REI IOWA-BIRCH COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
W249	<p>Continued From page 11</p> <p>noted there were alarms on all exit doors at the facility as well as Client #1's bedroom door. The program read, "Door alarms on facility doors will be on at all times when individuals are in the facility. (Client #1's) bedroom door alarm will be turned on any time (Client #1) is in (his/her) bedroom."</p> <p>Observations on the morning of 2/21/17 revealed the facility had three exits: a front entry/exit (inside door and outside door), a back door off the kitchen and a west door. The front inner door made a chime type of sound whenever the inner door was opened. The chime was turned on at all times and could only be turned off by accessing a locked plastic cover in another room. The door chime was not very loud but could be heard throughout the house. The front inner door, the back door and the west door were also alarmed by entering a code in a code box next to the front door and the west door. Staff could turn the alarms off or on at the three exits doors by entering the code at either the front door or the west door. Either of the code boxes controlled the alarms for all three doors. Client #1's bedroom window was also alarmed with the code alarm system used for the three exit doors. In addition, the west door had a very loud alarm that was turned off and on with a key. The west door was not typically used. Client #1's bedroom door had the same type of key alarm as the west door. The alarm was very loud when it sounded.</p> <p>Observation on the morning of 2/21/17 revealed the Shell gas station/convenience store could be seen from the facility. A frontage type of road connected the facility and gas station, at a distance of approximately 2-3 blocks. A person could also cut across and walk to the gas station.</p>	W249		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1603062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/22/2017
NAME OF PROVIDER OR SUPPLIER REH IOWA-BIRCH COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 29 EAST STREET SHELBY, IA 51870	
(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 249	<p>Continued From page 12</p> <p>but it seemed less likely Client #1 took this way since trees and buildings were in the way. The gas station was next to an off ramp for Interstate 80. A two lane road ran in front of the frontage road. The surveyor walked from the facility to the Shell station at a moderately brisk pace on the morning of 2/21/17 in approximately 3 1/2 minutes.</p> <p>When interviewed on 2/21/17 at 2:10 p.m., Direct Support Professional (DSP) A confirmed she worked at the time of the incident on 2/05/17. DSP A said she turned off the exit door alarms with the code at approximately 8:45 p.m. when DSP C knocked; DSP C had been at the house to pass evening medications. DSP A said staff typically turned the alarm back on after staff came in the door, but it was a busy hectic evening and she didn't get the alarm turned back on. DSP A said she helped get Client #1 ready for bed and he/she was in bed by 8:45 p.m. with the bedroom door shut. DSP A said she was aware Client #1's bedroom door alarm should have been turned on, but she got busy helping DSP B deal with a client who was aggressive. Client #1 yelled and cursed in his/her room about the client who was being aggressive and the noise level. DSP A estimated she last heard Client #1 yell around 9:15 p.m. DSP A later went to check on Client #1 and saw he/she was not in his/her bedroom. DSP A said she ran to tell DSP B Client #1 was missing and noticed the time on a clock was 9:20 p.m. She and DSP B searched the facility and opened the door to look outside. The sheriff's department called at 9:29 p.m. to tell them Client #1 was at the Shell station. DSP A went to the Shell station and brought the client back to the facility. DSP A said she knew the exit door alarms and Client #1's bedroom door alarm should have been</p>	W 249		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 160092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2017
NAME OF PROVIDER OR SUPPLIER RENI IOWA-BIRCH COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 249	<p>Continued From page 13</p> <p>turned on, but she did not recall if she had been trained on Client #1's elopement program. She said Client #1 had not threatened to leave the facility. When asked which of the staff were assigned to Client #1 at the time, DSP A said she did not think this was listed on the schedule.</p> <p>When interviewed on 2/12/17 at 1:55 p.m., DSP B confirmed she was working at the time of the incident on 2/05/17. She said DSP C came to the facility from approximately 8:15 p.m. to 8:45 p.m. to pass evening medications. On 2/5/17, DSP B and DSP A were busy with evening snack and dealing with a behavioral client and they did not turn the exit door alarm back on when DSP C left. DSP B estimated she last heard Client #1 yell from his/her bedroom around 9:15 p.m. DSP B recalled DSP A checked on Client #1 between 9:20 p.m. and 9:28 p.m. and saw he/she was not in his/her bedroom. The sheriff's department called at 9:29 p.m., just minutes after the staff noticed Client #1 missing (the phone recorded the time) and said Client #1 was at the Shell station. DSP B reported she had been trained on Client #1's elopement program and the need to have the door alarms on and was aware Client #1 had eloped to the Shell station in the past. When asked, DSP B reported the CMA usually called or texted when they are on their way and staff turned the alarm off. They usually turned the exit alarms back on after the medication passer walked into the house, but it was a very chaotic evening; another client was aggressive, and Client #1 and other clients yelled. DSP B reported Client #1 had been in his/her bedroom with the door shut, but the staff had been busy with the behavioral client and had not turned on Client #1's bedroom door alarm. DSP B stated Client #1 yelled and cursed from his/her room,</p>	W 249		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/LJA IDENTIFICATION NUMBER: 162052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2017
NAME OF PROVIDER OR SUPPLIER RENI IOWA-BIRCH COTTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 249	<p>Continued From page 14</p> <p>but did not threaten to leave. She estimated Client #1 was gone for 1/2 hour or less. DSP B said she did not know which of the two staff was assigned to Client #1 at the time of the elopement.</p> <p>When interviewed on 2/21/17 at 2:25 p.m., DSP C said she came to the facility on 2/05/17 around 8:15 p.m. to pass medications. She rang the bell and DSP A gave her a thumbs up sign through the window to indicate she had turned the alarm off. DSP C said she passed client medication and left about 45 minutes later; as far as she knew, the staff had not turned the exit door alarm back on when she left. DSP C reported the alarm did not sound when she left through the front door. She had told DSP A and DSP B she was leaving. DSP C said Client #1 was in his/her bedroom with the door shut when she left, and she knew that because she could hear him/her yelling. DSP C reported DSP A and DSP B were busy dealing with a behavioral client when she left in that client's bedroom.</p> <p>When interviewed on 2/21/17 at 9:25 a.m. the Program Coordinator (PC)/Qualified Intellectual Disability Professional (QIDP) stated two staff were present when Client #1 eloped on the evening of 2/05/17. The PC said the staff were busy dealing with another client's who tried to aggress toward a third client. The exit door alarms were not turned on at the time. Staff noticed Client #1 missing around 9:20 p.m. and searched the house and outside. The PC confirmed the door alarms should have been turned on at the time Client #1 eloped. The PC said when Client #1 had also eloped to the same nearby gas station/convenience store in June and October of 2016.</p>	W 249		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2017
NAME OF PROVIDER OR SUPPLIER REMI IOWA-BIRCH COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 249	Continued From page 15 Based on these findings a determination of IJ was made due to concerns with client safety. The facility was notified on 2/22/17 at 9:45 a.m.. The facility provided a plan, which included increased supervision for Client #1. The IJ was removed on 2/22/17 at approximately 12:15 p.m.	W 249		

Cal
3/29/17

Please accept this plan as the facilities credible plan of compliance.

✓f/c
3/29/17

W102: Facility Response:

483.410 GOVERNING BODY AND MANAGEMENT

The facility local "management team" (Lead Direct Support Professional, Program Coordinator and Program Director/QIDP) will ensure that individuals are receiving appropriate supervision and that there are clear and specific directions for Direct Support Professionals to follow regarding individual supervision needs and expectations. To increase the safety and protection of Client #1, due to his risk of elopement, Client #1's programming was updated 2/22/17 to include additional techniques and interventions for consistent staff supervision and the environment. One revision is that a bracelet system was implemented. Staff responsible for supervision of Client #1 will wear a colored bracelet at all times as a visual and physical reminder that they are responsible for knowing Client #1's whereabouts at all times. Also, client #1 will have a temporary increase in his level of supervision. Client #1 will have one-on-one supervision until the 15 second delayed egress locking system is installed in the facility. Installation began 3/13/17. All staff has been required to demonstrate their knowledge and competency with Client #1's elopement program, including utilizing the current alarm systems. When the new delayed egress system is complete, the fire marshal comes to the facility to approve the system for use (scheduled 3/15/17), Client #1's programming is revised and informed consent is obtained, all staff will be informed and receive support and training from management and be required to demonstrate their knowledge and competency in utilizing the new system and other changes that occur within the program (the 1:1 supervision will be removed from the program).

With the oversight of management, all staff is responsible to review (in a prompt and timely manner), be familiar with and knowledgeable about Client #1's elopement programming, to ensure his supervision, safety and support needs are met. Staff is responsible to sign-off on the corresponding training sheet(s). Staff will receive on-going support and training by management, including but not limited to: individual training, collective training via shift and/or staff meetings, as requested by staff, and via formal and informal observations.

On-going monitoring of compliance will occur by the facility Lead Direct Support Professional, Program Coordinator and Program Director/QIDP. On the spot feedback will be provided if instances occur when staff does not adhere to expectations.

Correction Date: 3/8/17

W104: Facility Response:

483.410(e)(1) GOVERNING BODY

The management team will ensure that elopement programs are revised in a prompt and timely manner to include clear and specific directions regarding individual supervision and safety. This includes, but is not limited to, training (knowledge and demonstration) on bedroom and facility door alarms, conducting and documenting bed checks, client specific supervision needs and providing supervision to individuals who wake up during the overnight hours. A fence was also installed (completion date 2/27/17) around the perimeter of the facility to help provide a visual boundary for staff and Client #1, as well as to help maintain Client #1's safety. Bi-weekly Interdisciplinary Team (IDT) Meetings were implemented, starting 2/10/17, to talk about Client #1's needs, including elopement. These meetings will continue until the IDT determines

otherwise. A dementia training for staff also took place 3/2/17 (it is believed that Client #1's dementia and sun downing are playing a role in his elopement. The "Individual & Employee Assignments Sheet" is being modified to provide clarity to staff when the number of staff working changes during a shift. This document will be reviewed with all staff with the intent of ensuring staff understand how the process works, have no additional questions or clarification at the time of the training, know who to reach out to if questions and/or concerns arise at a later time, and know the location(s) of this document. This training will be documented.

On-going monitoring of compliance will occur by the management team. On the spot feedback will be provided if instances occur when staff does not adhere to expectations. Cross reference response to W102.

Correction Date: 3/8/17

W249: Facility Response:

483.440(d)(1) PROGRAM IMPLEMENTATION

The management team will formally and informally provide support and supervision to staff to ensure that programs are implemented as written to help ensure the needs, supervision and safety of the individuals are met. All staff has been trained on Client #1's revised elopement program, including expectations related to safety, supervision and the operation of the current alarm systems. Staff is required to demonstrate their knowledge and competency in utilizing the alarm systems outlined in Client #1's elopement program. This training has been documented.

On-going monitoring of compliance will occur by the management team. On the spot feedback will be provided if instances occur when staff does not adhere to expectations. Cross reference response to W102 and W104.

Correction Date: 3/8/17