Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **FC # 6535**	**Total fine amount reduced by 35% to $4,875 on June 1, 2017 pursuant to Iowa Code Section 135C.43A**		**Date:** **May 12, 2017**
Facility Name: **REM Iowa–Aspen Cottage**		**Survey Dates:** **April 24-27, 2017**	
Facility Address/City/State/Zip **29 East Street** **Shelby IA. 51570**			
	HL	#67713-I.	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
64.60	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.** **Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.** **This rule is intended to implement Iowa Code Section 135C.2(3).** **DESCRIPTION:**	**I**	**$7000.00**	**Upon Receipt**
W159	**483.430(a) QIDP** **Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.**			
W191	**483.430 (e)(2) STAFF TRAINING PROGRAM** **For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs.** Based on observations, interviews and record reviews, the Qualified Intellectual Disabilities Professional			

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	(QIDP) failed to effectively monitor and coordinate services in order to meet client needs. This affected 1 of 1 client (Client #2) reviewed during investigation #67713-I. Finding follows: Intermittent observations throughout the survey revealed Client #2 walked towards the kitchen door and staff redirected him/her to another activity. Record review revealed the following: a. Client #2's incident report dated 4/15/17. The report indicated, Direct Support Professional (DSP) A and DSP B were getting Client #4 up for medications (meds) and Certified Medication Aide (CMA)/DSP) C was getting Client #1 up for meds. CMA/DSP D went next door to do another home's medications. Frozen beef stew had been on the stove ready for cooking. The report identified DSP A and DSP B had the kitchen door closed. Client #2 got into kitchen and ate a few pieces of meat. DSP A, DSP B, and CMA/DSP C didn't hear (him/her) get into kitchen. DSP A looked outside of Client #4's room door and saw Client #2 struggling. Client #2 had collapsed outside of med room door. DSP A and CMA/DSP C went over to Client #2, (he/she) was blue in color. Staff pulled 3 pieces of meat out of Client #2's mouth. Client #2 had another stuck. DSP A started to do the Heimlich; nothing happened. CMA/DSP C tried and nothing happened. DSP B ran over to another home to get CMA/DSP D. In the meantime DSP A called 911. They instructed us to begin CPR as (he/she) stopped breathing. Medivac showed up and took over. DSP A and DSP B followed Medivac...			

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	b. Client #2's Dietary Assessment dated 12/9/16. The assessment indicated Client #2 required visual supervision due to taking large bites, not chewing thoroughly, eating rapidly, and food stealing. c. Client #2's Comprehensive Functional Assessment (CFA) dated 8/29/16. The CFA indicated Client #2 had a history of stealing food. d. Client #2's Nursing Health Care Plan dated 2/17/17, indicated Client #2 at high risk for aspiration. When interviewed on 4/25/17 at 2:51 p.m. CMA/DSP D reported Client #2 got into the kitchen a lot. She stated he/she was very fast with taking food. CMA/DSP D also stated they try to redirect Client #2 from entering the kitchen because they do not want him/her to choke. When interviewed on 4/25/17 at 3:05 p.m. DSP B reported Client #2 was watched a lot more than other clients because he/she had tried to get into the kitchen before. She remembered one incident when Client #2 got into the kitchen and grabbed a handful of green beans. She stated she took the beans out of his/her hand before he/she could eat them. When interviewed on 4/26/17 at 3:23 p.m. DSP A reported Client #2 always tried to steal food. She stated Client #2 liked to get into the kitchen and he/she would eat anything and everything off of the floor. DSP A also stated if any client was in the living room a			

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AND W191	staff should be there with them. When interviewed on 4/26/17 at 3:00 p.m. the Program Director confirmed the facility did not have a program in place for Client #2's stealing food. She stated they are working on since his/her recent incident. Currently staff document when he/she steals food on an incident report. **Based on interviews and record reviews, the facility failed to ensure staff consistently demonstrated appropriate measures to address inappropriate client behavior. This pertained to 1 of 1 client (Client #2) reviewed during investigation #67713-I. Finding follows:** Record review revealed the following: a. Client #2's incident report dated 4/15/17. The report indicated, Direct Support Professional (DSP) A and DSP B were getting Client #4 up for medications (meds) and Certified Medication Aide (CMA)/DSP) C was getting Client #1 up for meds. CMA/DSP D went next door to do another home's medications. Frozen beef stew had been on the stove ready for cooking. The report identified DSP A and DSP B had the kitchen door closed. Client #2 got into kitchen and ate a few pieces of meat. DSP A, DSP B, and CMA/DSP C didn't hear (him/her) get into kitchen. DSP A looked outside of Client #4's room door and saw Client #2 struggling. Client #2 had collapsed outside of med room door. DSP A and CMA/DSP C went over to Client #2, (he/she) was blue in color. Staff pulled 3 pieces of meat out of Client #2's mouth. Client #2 had			

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	another stuck. DSP A started to do the Heimlich; nothing happened. CMA/DSP C tried and nothing happened. DSP B ran over to another home to get CMA/DSP D. In the meantime DSP A called 911. They instructed us to begin CPR as (he/she) stopped breathing. Medivac showed up and took over. DSP A and DSP B followed Medivac... Intermittent observations throughout the survey revealed Client #2 walked towards the kitchen door and staff redirected him/her to another activity. When interviewed on 4/25/17 at 2:51 p.m. CMA/DSP D reported Client #2 got into the kitchen a lot. She stated he/she was very fast with taking food. CMA/DSP D also stated they try to redirect Client #2 from entering the kitchen because they do not want him/her to choke. When interviewed on 4/25/17 at 3:05 p.m. DSP B reported Client #2 was watched a lot more than other clients because he/she had tried to get into the kitchen before. She remembered one incident when Client #2 got into the kitchen and grabbed a handful of green beans. She stated she took the beans out of his/her hand before he/she could eat them. When interviewed on 4/26/17 at 3:23 p.m. DSP A reported Client #2 always tried to steal food. She stated Client #2 liked to get into the kitchen and he/she would eat anything and everything off of the floor. DSP A also stated if any client was in the living room a staff should be there with them.			

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	When interviewed on 4/27/17 at 8:50 a.m. Program Coordinator (PC) reported staff should try to keep everyone in eyesight or know whereabouts. She stated when new staff shadow at the home, they talk about keeping clients in eyesight and know what is going on. PC was unsure if there is a protocol written down or just common knowledge. PC believed the choking incident with Client #2 happened because of a failure in communication which left Client #2 in the living room by him/herself. She stated Client #2 will go into the kitchen when food is left out. When interviewed on 4/27/17 at 10:00 a.m. the Program Director confirmed the facility should know the whereabouts of all clients. She stated the facility verbally trained staff and is not documented. Client #2's hospital report plan, dated 4/15/17, documented the following: This is a critically ill 40-year-old white (male/female) who had an episode of choking secondary to over ingestion requiring intubation and mechanical ventilation at this time. Due to (his/her) aggressiveness (he/she) was placed on deeper fan and is resting quietly at this time. Telephone consultation was obtained with the Physician at 7:16 p.m., in which case was presented and plan for bronchoscopy later this evening. Troponin noted as slightly elevated/indeterminate at 0.13. A telephone consult with Physician at 7:18 p.m. with discussion regarding treatment for type II non-ST elevated MI as previous EKG had been reviewed and did not reveal ST elevation. He/She is hypotensive at this point however stable and is receiving intravenous			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	fluids. This is likely secondary to recent initiation of deeper fan and beta blocker therapy. (He/She) will also receive rectal aspirin and formal cardiology's last coronary consultations will be obtained. Patient was monitored in the intensive care unit (ICU) overnight. He/She will receive pharmacological and nonpharmacological DVT prophylaxis in addition to PPI therapy for stress prophylaxis. OG will be ordered for insertion. Further recommendations pending hospital medicine physician staff assessment. Anticipated length of stay greater than 2 nights. Client #2's nursing notes from Registered Nurse (RN) A, dated 4/17/17. The notes indicated, RN A placed a phone call to the hospital for an update on Client #2. She documented Client #2 had problems over night with low stats. (He/she) is on oxygen, (he/she) is being moved out of Intensive Care Unit (ICU) today to med surg. unit. Client would have a speech consult done today. The hospital Final Report dated 4/17/17 revealed a comparison from 4/16/17 to 4/15/17 of the chest exam resulting in the nasogastric tube (NG) tube removed. Client #2 was improving in ventilation of the right lung. Client #2's discharge instructions dated 4/18/17, indicated a Client #2's discharge diagnoses included choking episode; Non-ST elevation MI (NSTEMI); Respiratory failure. A prescription of Prednisone was prescribed for four additional days after discharge. **FACILITY RESPONSE:**			

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50.7(1)a(2)a	**481—50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III):** **50.7(1) Of any accident causing major injury.** ***a.*** **"Major injury" shall be defined as any injury which:** **(2) Requires admission to a higher level of care for treatment, other than for observation; or** **DESCRIPTION:** Based on interview and record review, the facility failed to consistently ensure major incidents requiring admission to a higher level of care were identified and reported immediately to the appropriate State agencies. This affected 1 of 1 client (Client #2) reviewed during investigation #67713-I. Finding follows: Record review revealed the following:	**II**	**$500**	**Upon Receipt**

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	a. Record review revealed the following: a. Client #2's incident report dated 4/15/17. The report indicated, Direct Support Professional (DSP) A and DSP B were getting Client #4 up for medications (meds) and Certified Medication Aide (CMA)/DSP) C was getting Client #1 up for meds. CMA/DSP D went next door to do another home's medications. Frozen beef stew had been on the stove ready for cooking. The report identified DSP A and DSP B had the kitchen door closed. Client #2 got into kitchen and ate a few pieces of meat. DSP A, DSP B, and CMA/DSP C didn't hear (him/her) get into kitchen. DSP A looked outside of Client #4's room door and saw Client #2 struggling. Client #2 had collapsed outside of med room door. DSP A and CMA/DSP C went over to Client #2, (he/she) was blue in color. Staff pulled 3 pieces of meat out of Client #2's mouth. Client #2 had another stuck. DSP A started to do the Heimlich; nothing happened. CMA/DSP C tried and nothing happened. DSP B ran over to another home to get CMA/DSP D. In the meantime DSP A called 911. They instructed us to begin CPR as (he/she) stopped breathing. Medivac showed up and took over. DSP A and DSP B followed Medivac... b. Client #2's hospital report plan, dated 4/15/17, documented the following: This is a critically ill 40-year-old white (male/female) who had an episode of choking secondary to over ingestion requiring intubation and mechanical ventilation at this time. Due to (his/her) aggressiveness (he/she) was placed on deeper fan and is resting quietly at this time.			

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	Telephone consultation was obtained with the Physician at 7:16 p.m., in which case was presented and plan for bronchoscopy later this evening. Troponin noted as slightly elevated/indeterminate at 0.13. A telephone consult with Physician at 7:18 p.m. with discussion regarding treatment for type II non-ST elevated MI as previous EKG had been reviewed and did not reveal ST elevation. He/She is hypotensive at this point however stable and is receiving intravenous fluids. This is likely secondary to recent initiation of deeper fan and beta blocker therapy. (He/She) will also receive rectal aspirin and formal cardiology's last coronary consultations will be obtained. Patient was monitored in the intensive care unit (ICU) overnight. He/She will receive pharmacological and nonpharmacological DVT prophylaxis in addition to PPI therapy for stress prophylaxis. OG will be ordered for insertion. Further recommendations pending hospital medicine physician staff assessment. Anticipated length of stay greater than 2 nights. The Final Report dated 4/17/17 revealed a comparison from 4/16/17 to 4/15/17 of the chest exam resulting in the nasogastric tube (NG) tube removed. Client #2 was improving in ventilation of the right lung. c. Client #2's Speech Therapy report, dated 4/17/17, indicated the therapist recommended, "1) Mechanical soft diet with thin liquids 2) Meds crushed in puree 3) Upright and alert for all po (by mouth) intake 4) 1:1 assistance with po 5) ST to continue to follow for swallowing safety check." d. Client #2's discharge instructions dated 4/18/17,			

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	indicated a Client #2's discharge diagnoses included choking episode; Non-ST elevation MI (NSTEMI); Respiratory failure. A prescription of Prednisone was prescribed for four additional days after discharge. e. Client #2's nursing notes from Registered Nurse (RN) A, dated 4/17/17. The notes indicated, RN A placed a phone call to the hospital for an update on Client #2. She documented Client #2 had problems over night with low stats. (He/she) is on oxygen, (he/she) is being moved out of Intensive Care Unit (ICU) today to med surg. unit. Client would have a speech consult done today. Additional record review revealed Injuries, Incidents and Incident Reporting Policy/Procedure dated 6/2/16. The policy indicated, "...Per state law, the Administrator (in our case the program director or designee... will report to the Department of Inspections and Appeals (DIA) Complaint Unit within 24 hours, or the next business day: A. Any accident causing major injury. 1. "Major Injury" is defined as any injury which: Results in death; or Requires admission to a higher level of care for treatment, other than observations..." When interviewed on 4/27/17 at 9:10 a.m. RN A reported she called the hospital on 4/17/17 to get a report on Client #2. She stated the hospital never gave her a reason Client #2 needed to be admitted to the hospital. She just knew Client #2 had an incident report for choking. When interviewed on 4/24/17 at 12:26 p.m. the			

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	Program Director confirmed the incident not reported to the Department. The Program Director stated Client #2 was admitted to the hospital for observations. **FACILITY RESPONSE:**			

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