VSK 6/8/17 CAC 6/6/17

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

PRINTED: 05/12/2017
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
	16G049	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
~~REM IOWA ASPEN 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 A recertification survey was conducted on 4/24/17 - 4/27/17. Deficiencies were written at W104, and W323. In addition, Investigation #67713-I was conducted during the survey and resulted in deficiencies cited at W159, and W191. Iowa Administrative Code (IAC) Chapter 50.7(1)(a)(2) was also cited. See State Form.	W 000	Please see attached. POC 6/22/17	
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 interviews and record reviews, the facility failed to consistently adhere to established, written policies/procedures for incident management regarding peer to peer aggression. This potentially affected all clients residing in the home (Clients #1 - #8). Finding follows: Record review revealed Client #2's data collection for behavioral incidents indicated: a. 1/15/17 Client #2 hit Client #5 twice on his/her helmet. b. 2/20/17 Client #2 hit another peer. c. 3/3/17 Client #2 hit Client #7 multiple times. d. 3/9/17 Client #2 hit another peer. e. 3/23/17 Client #2 slapped Client #5 three times on the head. f. 3/24/17 Client #2 slapped Client #4 twice on the arm.	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle	PO	06/22/17

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 g. 3/25/17 Client #2 slapped Client #8. h. 3/30/17 Client #2 kicked Client #1 two times. Additional record review revealed Injuries, Incidents and Incident Reporting Policy/Procedure dated 6/2/16. The policy defined an incident as, "an unusual event involving an individual in service that causes harm, or risk of harm, to that individual or other person;" examples included peer to peer aggression. Incident Reports could not be located for Client #2's aggressions towards other clients. When interviewed on 3/27/17 at 10:00 a.m. the Program Director confirmed the facility failed to complete incident reports for the victims of Client #2's aggressions.	W 104		
W 159	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the Qualified Intellectual Disabilities Professional (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 #87713-I. Finding follows: Intermittent observations throughout the survey revealed Client #2 walked towards the kitchen door and staff redirected him/her to another activity.	W 159		

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W 159	Continued From page 2 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 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	W 159		

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W 159	Continued From page 3 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 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.	W 159		
W 191	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. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the	W 191		

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W 191	Continued From page 4 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 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.	W 191		

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W 191	Continued From page 5 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. 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.	W 191		

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W 191	Continued From page 6 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 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.	W 191		

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W 191	Continued From page 7 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.	W 191		
W 323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure clients received annual hearing screenings. This affected 2 of 4 sample clients (Client #1 and Client #3). Findings follow: 1. Record review revealed Client #1's hearing exam, dated 6/10/14. Additional record review revealed Nursing Functional Hearing Screening Test, dated 6/23/15. A current hearing exam could not be located. When interviewed on 4/27/17 at 9:10 a.m. Registered Nurse (RN) A confirmed the facility failed to complete an updated hearing assessment for Client #1.	W 323		

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W 323	Continued From page 8 2. Record review revealed Client #3's Quarterly Nursing Assessment, dated 1/30/17, indicated on 4/9/14 Client #3's hearing evaluation was attempted, but Client #3 had "too much head movement." Additional record review revealed Nursing Functional Hearing Screening Test dated 4/22/15. RN A documented "no indication of awareness of voice." A current hearing exam could not be located. When interviewed on 4/27/17 at 9:10 a.m. RN A confirmed the facility failed to complete an updated hearing exam for Client #3. She stated he/she was difficult to assess.	W 323		

DEPARTMENT OF INSPECTIONS AND APPEALS

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	IA0069	A. BUILDING: _____ B. WING _____	C 04/27/2017

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C 139	50.7(1)a(2) Additional notification 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: 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; This REQUIREMENT is not met as evidenced by: 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 #87713-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	C 139		

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C 139	Continued From page 1 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, indicated, "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 (Physician) at 1916 (hours) in which case was presented and plan for bronchoscopy later this evening. Troponin noted to be slightly elevated/indeterminate at 0.13. Telephone consult with (Physician) at 1918 (hours). Discussion was held regarding treatment for type II non-ST elevated MI as previous EKG has 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	C 139		

DEPARTMENT OF INSPECTIONS AND APPEALS

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C 139	Continued From page 2	C 139		

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 midnight."

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, indicated a Client #2's discharge diagnosis included, "Choking episode; Non-ST elevation MI (NSTEMI); Respiratory failure." A prescription of Prednisone was prescribed for four additional days after discharge.
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.

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 ICU today to med surg unit. Speech consult 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

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C 139	Continued From page 3 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 Program Director confirmed the incident not reported to the Department. The Program Director stated Client #2 was admitted to the hospital for observations.	C 139		

CAC 6/6/17 JL 6/8/17

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

W104: Facility Response:
The facility Program Coordinator and QIDP with oversight from the Program Director will ensure that incident management regarding peer to peer aggression policies and procedures are adhered to. The Injuries, Incidents and Incident Reporting procedure was revised on 04/27/17 to more clearly state the existing process for documenting peer to peer aggressions and what situations required an incident report to be completed. Our procedure indicates that "In the case where individual programming is in place (e.g. individual to employee aggression, peer to peer aggression, aggression toward objects, self-injurious behavior, lying) an Incident Report would not be completed due to these incidents being documented on the individual program plan data collection sheets." Staff will be retrained on peer to peer aggression, appropriate documentation and the revised incident reporting procedure. They will also be retrained on the expectation that if there is an incident of peer to peer aggression in which a peer is injured, an incident report must be completed on the individual who is injured. The facility Program Coordinator and QIDP will monitor behavior program data monthly and report any changes, patterns, or trends to the Program Director and program revisions will be discussed.

Correction Date: 6/22/17

W159: Facility Response:
The facility Program Coordinator and QIDP, with oversight and direction from the facility Program Director will ensure that services are effectively monitored and coordinated to meet client needs. Programs will be revised to include Client #2's food stealing and other measures to be put in place to further address this individual's safety. Staff will be trained on this program and appropriate implementation. Staff will also be retrained on dietary orders to ensure that client #2 is receiving the appropriate level of supervision and food modifications to ensure his safety. Programs will be reviewed monthly by the Program Coordinator and QIDP as part of the data summary process and will be evaluated for revisions to meet client needs. The Dietary Orders and Assessments (DAOs) will be reviewed and/or revised at least annually by the Program Coordinator, QIDP, facility Program Nurse, dietician and physician. They may be reviewed/revised more frequently if there are specific changes to client needs.

Correction Date: 5/12/17

W191: Facility Response:
The facility Program Coordinator and QIDP, with oversight and direction form the facility Program Director will ensure staff is trained on appropriate measures to address inappropriate client behavior. Programs will be revised to include Client #2's food stealing and other measures to be put in place to further address this individual's safety. Staff will be trained on this program to address dietary needs as well as appropriate interventions when displaying food stealing and appropriate implementation. Staff will also be retrained on dietary orders to ensure that client #2 is receiving the appropriate

level of supervision and food modifications to ensure his safety. Programs will be reviewed monthly by the Program Coordinator and QIDP as part of the data summary process and will be evaluated for revisions to meet client needs. The Dietary Orders and Assessments (DAOs) will be reviewed and/or revised at least annually by the Program Coordinator, QIDP, facility Program Nurse, dietician and physician. They may be reviewed/revised more frequently if there are specific changes to client needs.

Correction Date: 5/12/17

W323: Facility Response:
The facility Program Nurse and Program Coordinator, with oversight and direction from the facility Program Director/QIDP will schedule annual physical examinations, which includes an evaluation of vision and hearing for each individual. If individuals consistently refuse and fail to participate in these examinations, the nurse will complete assessments until the individual participates in these examinations. This process will be reviewed with nursing and supervisory personnel and monitored that it is ensured moving forward. The Nursing Director conducts random nursing file audits during the year and will note any inconsistencies with this expectation and specific training and/or feedback will be provided if not adhered to.

Correction Date: 6/22/17

C139: Facility Response:
The facility Program Director, with oversight and direction from the Regional Director will ensure that major injuries requiring admission to a higher level of care for treatment other than for observation are identified and reported to the DIA complaint unit within 24 hours, or the next business day. Additionally, all supervisory personnel and nursing staff will receive direction indicating that choking incidents that result in admission to a higher level of care for treatment will be considered a "major injury" and thus reportable to DIA. Also, they will receive training on Chapter 50.7 on reportable incidents to ensure all leadership and nursing personnel are aware of what is a reportable incident and the chain of communication that should be followed when there is a possible reportable incident so that we can adhere to all licensing requirements. These types of incidents that require reporting will be monitored through incident reporting, verbal reports from staff, nursing and leadership personnel and the Individual Health/Medical Weekly Update email communications. Retraining and follow up will occur if incidents occur where this process isn't completed.

Correction Date: ~~6/22/17~~ 5/12/17 per Rachel Neill CAC 6/16/17
