CAC 6/6/17 ✓ 6/8/17

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

PRINTED: 05/19/2017
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
	16G052	A. BUILDING _____ B. WING _____	05/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-BIRCH COTTAGE	29 EAST STREET SHELBY, IA 51570

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The annual health facility survey resulted in a determination of Immediate Jeopardy (IJ), due to concerns with client safety. The facility was notified of the IJ on 4/26/17 at approximately 4:00 p.m. The facility responded with corrective actions to address the identified problems and system practices. The IJ was removed on 5/2/17. The facility was found to be out of compliance with the following Conditions of Participation: Governing Body and Management. A deficiency was cited at W104. Client Protections. A deficiency was cited at W149.	W 000	See attached POC 6/19/17	
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on 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 adequately ensure incidents of client to client aggression were monitored, tracked and addressed. The investigation resulted in a determination of immediate jeopardy (IJ), due to concerns with clients' health and safety. The facility was notified of the IJ on 4/26/17. The IJ was removed on 5/2/17.	W 102		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Stoffa	Regional Director	05/26/17

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 102	Continued From page 1 Cross reference W104: Based on interviews and record review, the facility failed to ensure appropriate monitoring, tracking and follow up of client to client aggression, and whether the aggressions resulted in client injuries Cross reference Condition of Participation: Client Protections W122 and W149	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure appropriate monitoring and tracking of client to client aggression, and whether the aggressions resulted in client injuries. This affected 5 of 8 clients residing at the facility (Clients #1, #3, #4, #6 and #7). Finding follows: Record review on 4/24/17 revealed Incident Reports for the past year for the eight clients residing at the facility. The surveyor identified a minimal amount of Incident Reports provided and questioned the Program Director. For instance, there were several Incident Reports for Client #6 regarding seizures and falls from May to July 2016, but none since then. During interview on 4/24/17 at 2:30 p.m. the Program Director (PD) stated it was possible additional Incident Reports had been misplaced or possible that staff had not written them. She said Client #6's seizure activity had decreased recently. The Incident Reports	W 104		

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W 104	Continued From page 2 presented on 4/24/17 contained only two incidents of peer to peer aggression: a) Client #7 hit Client #1 on 2/27/17, which did not cause an injury; b) Client #5 slapped Client #4 in the forehead on 2/06/17, with no resulting injury. Record review of Client #1's chart on 4/25/17 revealed a discharge form from the emergency room on 2/08/17 for abrasions to the face and a small laceration to the eye. According to a nursing note dated 2/09/17, Client #1 had abrasions to the right side of face caused by another client's aggression. No Incident Report regarding this incident could be located. When interviewed on 4/15/17 at 3:15 p.m. the PD stated she did not recall seeing an Incident Report for the incident on 2/08/17 when Client #1 went to the emergency room for injuries sustained as a result of aggression by Client #7. The PD noted the Program Coordinator was gone and might have additional Incident Reports in her office. When questioned about the tracking process for client to client aggression that result in injuries, the PD said she kept track informally on her calendar. When asked to show her 2017 calendar to the surveyor, the PD stated she had not documented any peer to peer aggressions with injuries since the first of the year. The PD said she had recently talked with staff about writing Incident Reports as needed because she felt like she was not getting as many Incident Reports as she should, including injuries of unknown origin. The PD said she had discussed this with staff at the March staff meeting. The PD was unable to produce minutes of the March meeting that showed the topic of Incident Reports was addressed, but she did have a hand written note stating she had encouraged staff to write	W 104		

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W 104	Continued From page 3 Incident Reports when needed. The PD provided a few additional Incident Reports on 4/25/17 at 2:50 p.m. None of the Incident Reports noted client to client aggression. The PD provided more Incident Reports on the morning and afternoon of 4/26/17. None of them noted client to client aggression, although they did document incidents of aggression toward staff, self-injurious behaviors, client injuries and one case of a client attempting to aggress toward another client. Additional record review on the afternoon of 4/26/17 revealed client behavior data sheets for Client #1 and Client #7 from January 2017 to March 2017. The behavior data sheets documented multiple incidents of client to client aggression as follows: a) On 1/06/17, Client #1 "started kicking" Client #6. There was no documentation of whether or not an injury occurred. b) On 1/20/17, Client #1 told Client #4 what to do and "started pulling on (his/her) arm." There was no documentation of whether or not and injury occurred. c) On 2/05/17, Client #1 got into an altercation with Client #7 and Client #1 bit Client #7 on his/her wrist. There was no documentation of whether or not an injury occurred. d) On 2/08/17, Client #1 got into an altercation with Client #7. Client #7 aggressed toward Client #1, who then bit Client #7. There was no documentation regarding injury to either client on the behavior form for Client #1, however the behavior form for Client #7 noted Client #1 was injured. e) On 3/24/17, Client #1 "started pushing peers" and threw items and hit Client #3. There was no	W 104		

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W 104	Continued From page 4 documentation of whether an injury occurred. f) On 3/29/17, Client #1 "slapped" Client #6. There was no documentation of whether an injury occurred. g) On 3/31/17, Client #1 yelled and pushed Client #3. There was no documentation of whether there was an injury h) On 1/06/17, Client #7 "started punching" Client #6 in the chest. Regarding whether there was an injury, staff circled both the yes and no response on the form. i) On 1/09/17, Client #7 punched Client #6 in the back. Staff documented no injury. j) On 2/08/17, Client #7 aggressed toward Client #1. Staff documented injury to Client #1's face, but did not note the client went to the emergency room. k) On 2/27/17, Client #7 "started hitting" Client #1. Staff documented there was no injury. This was the only incident of client to client aggression that had a corresponding Incident Report. Further record review revealed no corresponding incident reports, no documentation of supervisory or programmatic follow up on any of the incidents of client to client aggression that did not have an Incident Report, no investigation or internal review of the incidents. When interviewed on 4/26/17 at 1:35 p.m. and asked if anyone at the agency tracked client to client aggressions, the PD said the former Qualified Intellectual Disability Professional (current Program Coordinator) might have been tracking or monitoring them, but that person was on an extended leave. The PD said the client monthly data summaries might indicate the frequency of client to client aggressions, however review of the monthly summaries revealed only	W 104		

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W 104	Continued From page 5 the number of total aggressions, which included aggression toward staff. The monthly data summaries provided no information regarding client injuries caused by aggression or any changes made to the behavior programs. When interviewed on 4/26/17 at 2:30 p.m. Direct Support Professional (DSP) A said she worked at the facilty for about 10 years. She said her understanding was to write an Incident Report anytime a client aggressed toward another client, regardless of whether there was an injury. She said an Incident Report should also be written if a client went to the emergency room. When interviewed on 4/26/17 at 2:40 p.m. DSP B stated she worked at the facility for about six months. She said Incident Reports were only completed for client to client aggression if one of the clients was injured. DSP B said she thought there had been discussion at a recent staff meeting regarding the need to write Incident Reports. She also recalled discussions at staff meetings regarding how to best address Client #7's behavioral issues, including aggression. When interviewed on 4/26/17 at 2:50 p.m. DSP C said she worked at the facility for almost one year. She said Incident Reports were only completed for client to client aggression if there was an injury. DSP C recalled there was discussion at a recent staff meeting reminding staff to write Incident Reports. When asked if there were any new or recent changes to Client #7's behavioral interventions, DSP C said staff just needed to keep reassuring the client when he/she got upset. According to the facility policy entitled Injuries,	W 104		

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W 104	Continued From page 6 Incidents and Incident Reporting the purpose of the policy was "To ensure that individual injuries and other incidents related to individuals served, are clearly documented, promptly reported and responded to in an appropriate and timely manner." Incidents listed included peer to peer aggression. However the policy indicated that Incident Reports would not need to be completed if clients had programming in place and the incident was documented elsewhere, such as on a behavior data sheet. When interviewed on 4/17/17 at 10:10 a.m. regarding the Incident Report policy the PD said in the case of client to client aggression, an Incident Report would not need to be completed for the aggressive client if that client had a behavior program in place with data collection. However, an Incident Report should be written for the client who was the victim of the aggression, regardless of whether there was an injury at that time, because an injury could show up later.	W 104		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. 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) Client Protections. The facility failed to implement a system to monitor, track and address incidents of client to client aggression. Multiple incidents of client to client aggression were noted on behavioral data forms from January 2017 through	W 122		

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W 122	Continued From page 7 March 2017, but the facility failed to implement a system to identify the scope of the problem and how to address it. The investigation resulted in a determination of immediate jeopardy (IJ), due to concerns with clients' health and safety. The facility was notified of the IJ on 4/26/17. The IJ was removed on 5/2/17. Cross reference W149: Based on interviews and record reviews, the facility failed to implement a system to track, monitor and address incidents of client to client aggression.	W 122		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement a system to track, monitor and address incidents of client to client aggression. This affected 5 of 8 clients residing at the facility (Clients #1, #3, #4, #6 and #7). Findings follow: Record review on 4/24/17 revealed Incident Reports for the past year for the eight clients residing at the facility. The surveyor identified a minimal amount of Incident Reports provided and questioned the Program Director. For instance, there were several Incident Reports for Client #6 regarding seizures and falls from May to July 2016, but none since then. During interview on 4/24/17 at 2:30 p.m. the Program Director (PD) stated it was possible additional Incident Reports had been misplaced or possible that staff had not	W 149		

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W 149	Continued From page 8 written them. She said Client #6's seizure activity had decreased recently. The Incident Reports presented on 4/24/17 contained only two incidents of peer to peer aggression: a) Client #7 hit Client #1 on 2/27/17, which did not cause an injury; b) Client #5 slapped Client #4 in the forehead on 2/06/17, with no resulting injury. Record review of Client #1's chart on 4/25/17 revealed a discharge form from the emergency room on 2/08/17 for abrasions to the face and a small laceration to the eye. According to a nursing note dated 2/09/17, Client #1 had abrasions to the right side of face caused by another client's aggression. No Incident Report regarding this incident could be located. When interviewed on 4/15/17 at 3:15 p.m. the PD stated she did not recall seeing an Incident Report for the incident on 2/08/17 when Client #1 went to the emergency room for injuries sustained as a result of aggression by Client #7. The PD noted the Program Coordinator was gone and might have additional Incident Reports in her office. When questioned about the tracking process for client to client aggression that resulted in injuries, the PD said she kept track informally on her calendar. When asked to show her 2017 calendar to the surveyor, the PD stated she had not documented any peer to peer aggressions with injuries since the first of the year. The PD said she had recently talked with staff about writing Incident Reports as needed because she felt like she was not getting as many Incident Reports as she should, including injuries of unknown origin. The PD said she had discussed this with staff at the March staff meeting. The PD was unable to produce minutes of the March meeting that showed the topic of	W 149		

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W 149	Continued From page 9 Incident Reports was addressed, but she did have a hand written note stating she had encouraged staff to write Incident Reports when needed. The PD provided a few additional Incident Reports on 4/25/17 at 2:50 p.m. None of the Incident Reports noted client to client aggression. The PD provided more Incident Reports on the morning and afternoon of 4/26/17. None of them noted client to client aggression, although they did document incidents of aggression toward staff, self-injurious behaviors, client injuries and one case of a client attempting to aggress toward another client. Additional record review on the afternoon of 4/26/17 revealed client behavior data sheets for Client #1 and Client #7 from January 2017 to March 2017. The behavior data sheets documented multiple incidents of client to client aggression as follows: a) On 1/06/17, Client #1 "started kicking" Client #6. There was no documentation of whether or not an injury occurred. b) On 1/20/17, Client #1 told Client #4 what to do and "started pulling on (his/her) arm." There was no documentation of whether or not and injury occurred. c) On 2/05/17, Client #1 got into an altercation with Client #7 and Client #1 bit Client #7 on his/her wrist. There was no documentation of whether or not an injury occurred. d) On 2/08/17, Client #1 got into an altercation with Client #7. Client #7 aggressed toward Client #1, who then bit Client #7. There was no documentation regarding injury to either client on the behavior form for Client #1, however the behavior form for Client #7 noted Client #1 was	W 149		

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W 149	Continued From page 10 injured. e) On 3/24/17, Client #1 "started pushing peers" and threw items and hit Client #3. There was no documentation of whether an injury occurred. f) On 3/29/17, Client #1 "slapped" Client #6. There was no documentation of whether an injury occurred. g) On 3/31/17, Client #1 yelled and pushed Client #3. There was no documentation of whether there was an injury h) On 1/06/17, Client #7 "started punching" Client #6 in the chest. Regarding whether there was an injury, staff circled both the yes and no response on the form. i) On 1/09/17, Client #7 punched Client #6 in the back. Staff documented no injury. j) On 2/08/17, Client #7 aggressed toward Client #1. Staff documented injury to Client #1's face, but did not note the client went to the emergency room. k) On 2/27/17, Client #7 "started hitting" Client #1. Staff documented there was no injury. This was the only incident of client to client aggression that had a corresponding Incident Report. Further record review revealed no corresponding incident reports, no documentation of supervisory or programmatic follow up on any of the incidents of client to client aggression that did not have an Incident Report, no investigation or internal review of the incidents. When interviewed on 4/26/17 at 1:35 p.m. and asked if anyone at the agency tracked client to client aggressions, the PD said the former Qualified Intellectual Disability Professional (current Program Coordinator) might have been tracking or monitoring them, but that person was on an extended leave. The PD said the client	W 149		

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W 149	Continued From page 11 monthly data summaries might indicate the frequency of client to client aggressions, however review of the monthly summaries revealed only the number of total aggressions, which included aggression toward staff. The monthly data summaries provided no information regarding client injuries caused by aggression or any changes made to the behavior programs. When interviewed on 4/26/17 at 2:30 p.m. Direct Support Professional (DSP) A said she worked at the facility for about 10 years. She said her understanding was to write an Incident Report anytime a client aggressed toward another client, regardless of whether there was an injury. She said an Incident Report should also be written if a client went to the emergency room. When interviewed on 4/26/17 at 2:40 p.m. DSP B stated she worked at the facility for about six months. She said Incident Reports were only completed for client to client aggression if one of the clients was injured. DSP B said she thought there had been discussion at a recent staff meeting regarding the need to write Incident Reports. She also recalled discussions at staff meetings regarding how to best address Client #7's behavioral issues, including aggression. When interviewed on 4/26/17 at 2:50 p.m. DSP C said she worked at the facility for almost one year. She said Incident Reports were only completed for client to client aggression if there was an injury. DSP C recalled there was discussion at a recent staff meeting reminding staff to write Incident Reports. When asked if there were any new or recent changes to Client #7's behavioral interventions, DSP C said staff just needed to keep reassuring the client when	W 149		

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W 149	Continued From page 12 he/she got upset. According to the facility policy entitled Injuries, Incidents and Incident Reporting the purpose of the policy was "To ensure that individual injuries and other incidents related to individuals served, are clearly documented, promptly reported and responded to in an appropriate and timely manner." Incidents listed included peer to peer aggression. However the policy indicated that Incident Reports would not need to be completed if clients had programming in place and the incident was documented elsewhere, such as on a behavior data sheet. When interviewed on 4/17/17 at 10:10 a.m. regarding the Incident Report policy the PD said in the case of client to client aggression, an Incident Report would not need to be completed for the aggressive client if that client had a behavior program in place with data collection. However, an Incident Report should be written for the client who was the victim of the aggression, regardless of whether there was an injury at that time, because an injury could show up later.	W 149		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interviews and record review the facility failed to allow for food choices based on individual client needs and preferences. This affected 2 of 3 sample clients who had the ability to communicate their preferences (Client #1 and Client #5). Finding follows:	W 247		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 247	Continued From page 13 Observation at the day program on 4/25/17 at 11:25 a.m. revealed Client #1 unpacked his/her lunch (turkey sandwich, radishes, graham crackers, cantaloupe) and shoved all of the food away. Client #1 said he/she did not want any of the food and told staff to throw it away. A staff person took the food back to the kitchen. Client #1 asked for crackers and proceeded to eat saltine crackers and drink a glass of milk. Observation at 11:35 a.m. revealed Client #1 threw away the food in his/her lunch bag into the kitchen garbage can. The surveyor asked staff if Client #1 could have a substitute lunch. Staff offered Client #1 a jelly sandwich and the client agreed. The surveyor asked Client #1 if he/she liked peanut butter. Staff present said the facility did not allow peanut butter at the facility because it was a choking hazard. The ban was not due to any particular client, it was an agency wide practice. Client #1 said he/she liked peanut butter. When asked about it, Client #5 said he/she liked peanut butter also. Record review on 4/25/17 and 4/26/17 of the charts for Client #1 and Client #5 revealed no reason they could not have peanut butter. Both clients had general texture diets or bite sized pieces of food. The peanut butter restriction was not noted anywhere in their records. When interviewed on 4/25/17 at 3:15 p.m. the Program Director said it was her understanding that it was REM policy/practice that peanut butter was not allowed in the facilities. She said this was due to concern about peanut butter being a choking hazard. No clients were allowed to have peanut butter.	W 247		
W 322	483.460(a)(3) PHYSICIAN SERVICES	W 322		

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W 322	Continued From page 14 The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure preventative health care procedures for clients in accordance with their needs. This affected 2 of 4 sample clients (Client #1 and Client #7). Findings follow: 1. Record review on 4/25/17 revealed Client #1 (age 50) had a colonoscopy done in May, 2012. According to the follow up instructions, the physician recommended a repeat colonoscopy in three years, which would have been 2015. No further documentation regarding a second colonoscopy could be located in Client #1's chart. There was no mention of it in the client's Plan of Care dated 10/07/16. Client #1's chart also contained a medical form dated 8/08/11 regarding follow up for a hysterectomy. The form read, "No pap smear for 5 years after hysterectomy." No additional documentation could be located in the chart regarding pap/pelvic exams. There was no mention of it in Client #1's Plan of Care dated 10/07/16. When interviewed on 4/26/17 at 11:00 a.m. the facility nurse said she had worked for the facility for about nine months. She was not aware of any discussion regarding colonoscopy or pap/pelvic exam for Client #1. To her knowledge, the procedures had not been done in the past few years.	W 322		

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W 322	Continued From page 15 2. Record review on 4/26/17 revealed Client #7 was 56 years old. There was no information in Client #7's chart regarding colonoscopy or a fecal occult blood test. It was not mention on his/her annual physical or the annual Plan of Care dated 3/10/17. When interviewed on 4/27/16 at 8:45 a.m. the facility nurse said she had no knowledge of Client #7 having a fecal occult blood test or colonoscopy. She had not had a discussion about it with Client #7's physician or guardian.	W 322		
W 352	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all clients received an annual dental exam. This affected 1 of 4 sample clients (Client #1). Finding follows: Record review on 4/25/17 revealed Client #1's most recent dental exam was 12/16/15. According to the Quarterly Nursing Assessment dated 4/03/17 the nurse had unsuccessfully attempted to contact Client #1's guardian to make a dental appointment with a new provider, as the previous dentist had moved out of state. As of 4/25/17, no dental appointment was scheduled and sixteen months had passed since the last dental exam.	W 352		

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W 352	Continued From page 16 When interviewed on 4/26/17 at 11:00 a.m. the facility nurse said she had sent a release form to the guardian in September 2016, which was not returned. The nurse stated she had also reminded the guardian about signing the release during phone conversations, but the guardian was difficult to reach. The nurse reviewed her nursing notes and found an entry dated 9/12/16 indicating she had sent the dental paperwork to the guardian. No further documentation regarding contacting the guardian about a dental appointment could be located. The guardian and the nurse both attended Client #1's annual Plan of Care meeting held in October 2016, but the nurse said it didn't occur to her at that time to have the guardian sign the release for the new dentist.	W 352		

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

W102: Facility Response:
The facility QIDP with oversight from the Program Director will ensure that incidents of peer to peer aggression are monitored, tracked and addressed. The facility created and implemented a Peer to Peer Aggression Protocol which provided a general protocol for monitoring, accessing, evaluating patterns for ways to address, with the ultimate goal of creating a safer environment for individuals receiving services. Cross reference response to W104 for additional information.

Correction Date: 05/1917

W104: Facility Response:
The facility 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 (PC) had failed to consistently follow the written procedures regarding incidents and incident reporting and is no longer in the position. When a replacement PC is hired they will be trained on these expectations and will then be included in the monitoring process that these procedures will be followed appropriately. Until consistent implementation and documentation is ensured, peer to peer aggression behavior tracking sheets will be reviewed on a weekly basis by the Program Director and/or QIDP to ensure continue monitoring of these programs and to determine if revisions need to be made and to also ensure that incidents of peer to peer aggression resulting in an injury to a peer are tracked and reported in a timely matter as appropriate. The facility QIDP and PC (when hired) will monitor behavior program data monthly and report any changes, patterns, or trends to the Program Director and program revisions will be discussed and made as needed to address the reduction of peer to peer injuries and increase the overall safety for individuals receiving services.

Correction Date: 05/19/17

W122: Facility Response:
Cross reference responses to W102 and W104. In addition, revisions to two specific individual's programming for aggression were revised as the way they were written

made it appear that their data for peer to peer aggressions was artificially inflated due to combining aggression toward others, aggression toward objects and verbal aggressions all in one IPP/total number of aggressions. The Peer to Peer Aggression Protocol will be utilized to evaluate what specific steps will be utilized to address patterns of aggressions toward peers and aggressions toward peers that cause injury. These steps to address aggressions will be individually based on each individual situation and the most appropriate methods to address, reduce the aggressions and increase the safety of the living environment for individuals being served will be considered and implemented.

Correction Date: 05/19/17

W149: Facility Response:
Cross reference responses to W102, W104 and W122.

Correction Date: 05/19/17

W247: Facility Response:
The facility QIDP with oversight from the Program Director will ensure that food choices based on individual client needs and preferences are provided, which includes peanut butter. Peanut butter or other food restrictions will only be considered if there is a specific safety concern with their dietary assessment and orders and/or eating/choking hazards. Any food restrictions will be documented in the individual's dietary assessment and orders and/or other individual records. Peanut butter was made available at the time of the survey and will continue to be made available going forward. Facility staff were notified of this immediate change regarding peanut butter. The facility nurse, Program Coordinator (when hired, QIDP, and Program Director will ensure that any food restrictions are consistent with the individuals needs and are documented appropriately. At a minimum food restrictions and the dietary assessment and orders will be reviewed at least annually.

Correction Date: 06/19/17

W323: Facility Response:
The facility Program Nurse and Program Coordinator (when hired), with oversight and direction from the facility Program Director/QIDP will ensure preventative health care procedures for individuals receiving services are completed in accordance with their needs. Specific examples (i.e. pap smear, colonoscopy and/or fecal occult blood test) cited during the survey will have appointments scheduled to address the healthcare needs that were noted as deficient. Going forward the nurse will ensure that preventative healthcare is scheduled appropriately for individuals based on their needs, age and gender. This process will be reviewed with nursing 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: 06/19/17

W352: Facility Response:

The facility Program Nurse and Program Coordinator (when hired), with oversight and direction from the facility Program Director/QIDP will schedule annual dental examinations. In the example cited further attempts to obtain consent for the individual to see another dentist will be made and documented. Once guardian approval is received a dental exam will be scheduled. If dentists don't recommend annual dental examinations for individuals, on off years the nurse will conduct an annual dental health screening and document such in the individual's medical record. This process will be reviewed with nursing 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: 06/19/17

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W 000	INITIAL COMMENTS The annual health facility survey resulted in a determination of Immediate Jeopardy (IJ), due to concerns with client safety. The facility was notified of the IJ on 4/26/17 at approximately 4:00 p.m. The facility responded with corrective actions to address the identified problems and system practices. The IJ was removed on 5/2/17. The facility was found to be out of compliance with the following Conditions of Participation: Governing Body and Management. A deficiency was cited at W104. Client Protections. A deficiency was cited at W149.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on 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 adequately ensure incidents of client to client aggression were monitored, tracked and addressed. The investigation resulted in a determination of immediate jeopardy (IJ), due to concerns with clients' health and safety. The facility was notified of the IJ on 4/26/17. The IJ was removed on 5/2/17.	W 102		

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

Dawn Stoft, Regional Director 05/26/17

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 102	Continued From page 1 Cross reference W104: Based on interviews and record review, the facility failed to ensure appropriate monitoring, tracking and follow up of client to client aggression, and whether the aggressions resulted in client injuries Cross reference Condition of Participation: Client Protections W122 and W149	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure appropriate monitoring and tracking of client to client aggression, and whether the aggressions resulted in client injuries. This affected 5 of 8 clients residing at the facility (Clients #1, #3, #4, #6 and #7). Finding follows: Record review on 4/24/17 revealed Incident Reports for the past year for the eight clients residing at the facility. The surveyor identified a minimal amount of Incident Reports provided and questioned the Program Director. For instance, there were several Incident Reports for Client #6 regarding seizures and falls from May to July 2016, but none since then. During interview on 4/24/17 at 2:30 p.m. the Program Director (PD) stated it was possible additional Incident Reports had been misplaced or possible that staff had not written them. She said Client #6's seizure activity had decreased recently. The Incident Reports	W 104		

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W 104	Continued From page 2 presented on 4/24/17 contained only two incidents of peer to peer aggression: a) Client #7 hit Client #1 on 2/27/17, which did not cause an injury; b) Client #5 slapped Client #4 in the forehead on 2/06/17, with no resulting injury. Record review of Client #1's chart on 4/25/17 revealed a discharge form from the emergency room on 2/08/17 for abrasions to the face and a small laceration to the eye. According to a nursing note dated 2/09/17, Client #1 had abrasions to the right side of face caused by another client's aggression. No Incident Report regarding this incident could be located. When interviewed on 4/15/17 at 3:15 p.m. the PD stated she did not recall seeing an Incident Report for the incident on 2/06/17 when Client #1 went to the emergency room for injuries sustained as a result of aggression by Client #7. The PD noted the Program Coordinator was gone and might have additional Incident Reports in her office. When questioned about the tracking process for client to client aggression that result in injuries, the PD said she kept track informally on her calendar. When asked to show her 2017 calendar to the surveyor, the PD stated she had not documented any peer to peer aggressions with injuries since the first of the year. The PD said she had recently talked with staff about writing Incident Reports as needed because she felt like she was not getting as many Incident Reports as she should, including injuries of unknown origin. The PD said she had discussed this with staff at the March staff meeting. The PD was unable to produce minutes of the March meeting that showed the topic of Incident Reports was addressed, but she did have a hand written note stating she had encouraged staff to write	W 104		

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W 104	Continued From page 3 Incident Reports when needed. The PD provided a few additional Incident Reports on 4/25/17 at 2:50 p.m. None of the Incident Reports noted client to client aggression. The PD provided more Incident Reports on the morning and afternoon of 4/26/17. None of them noted client to client aggression, although they did document incidents of aggression toward staff, self-injurious behaviors, client injuries and one case of a client attempting to aggress toward another client. Additional record review on the afternoon of 4/26/17 revealed client behavior data sheets for Client #1 and Client #7 from January 2017 to March 2017. The behavior data sheets documented multiple incidents of client to client aggression as follows: a) On 1/06/17, Client #1 "started kicking" Client #6. There was no documentation of whether or not an injury occurred. b) On 1/20/17, Client #1 told Client #4 what to do and "started pulling on (his/her) arm." There was no documentation of whether or not and injury occurred. c) On 2/05/17, Client #1 got into an altercation with Client #7 and Client #1 bit Client #7 on his/her wrist. There was no documentation of whether or not an injury occurred. d) On 2/08/17, Client #1 got into an altercation with Client #7. Client #7 aggressed toward Client #1, who then bit Client #7. There was no documentation regarding injury to either client on the behavior form for Client #1, however the behavior form for Client #7 noted Client #1 was injured. e) On 3/24/17, Client #1 "started pushing peers" and threw items and hit Client #3. There was no	W 104		

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W 104	Continued From page 4 documentation of whether an injury occurred. f) On 3/29/17, Client #1 "slapped" Client #6. There was no documentation of whether an injury occurred. g) On 3/31/17, Client #1 yelled and pushed Client #3. There was no documentation of whether there was an injury h) On 1/06/17, Client #7 "started punching" Client #6 in the chest. Regarding whether there was an injury, staff circled both the yes and no response on the form. i) On 1/09/17, Client #7 punched Client #6 in the back. Staff documented no injury. j) On 2/08/17, Client #7 aggressed toward Client #1. Staff documented injury to Client #1's face, but did not note the client went to the emergency room. k) On 2/27/17, Client #7 "started hitting" Client #1. Staff documented there was no injury. This was the only incident of client to client aggression that had a corresponding Incident Report. Further record review revealed no corresponding incident reports, no documentation of supervisory or programmatic follow up on any of the incidents of client to client aggression that did not have an Incident Report, no investigation or internal review of the incidents. When interviewed on 4/26/17 at 1:35 p.m. and asked if anyone at the agency tracked client to client aggressions, the PD said the former Qualified Intellectual Disability Professional (current Program Coordinator) might have been tracking or monitoring them, but that person was on an extended leave. The PD said the client monthly data summaries might indicate the frequency of client to client aggressions, however review of the monthly summaries revealed only	W 104		

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W 104	Continued From page 5 the number of total aggressions, which included aggression toward staff. The monthly data summaries provided no information regarding client injuries caused by aggression or any changes made to the behavior programs. When interviewed on 4/26/17 at 2:30 p.m. Direct Support Professional (DSP) A said she worked at the facility for about 10 years. She said her understanding was to write an Incident Report anytime a client aggressed toward another client, regardless of whether there was an injury. She said an Incident Report should also be written if a client went to the emergency room. When interviewed on 4/26/17 at 2:40 p.m. DSP B stated she worked at the facility for about six months. She said Incident Reports were only completed for client to client aggression if one of the clients was injured. DSP B said she thought there had been discussion at a recent staff meeting regarding the need to write Incident Reports. She also recalled discussions at staff meetings regarding how to best address Client #7's behavioral issues, including aggression. When interviewed on 4/26/17 at 2:50 p.m. DSP C said she worked at the facility for almost one year. She said Incident Reports were only completed for client to client aggression if there was an injury. DSP C recalled there was discussion at a recent staff meeting reminding staff to write Incident Reports. When asked if there were any new or recent changes to Client #7's behavioral interventions, DSP C said staff just needed to keep reassuring the client when he/she got upset. According to the facility policy entitled Injuries,	W 104		

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W 104	Continued From page 6 Incidents and Incident Reporting the purpose of the policy was "To ensure that individual injuries and other incidents related to individuals served, are clearly documented, promptly reported and responded to in an appropriate and timely manner." Incidents listed included peer to peer aggression. However the policy indicated that Incident Reports would not need to be completed if clients had programming in place and the incident was documented elsewhere, such as on a behavior data sheet. When interviewed on 4/17/17 at 10:10 a.m. regarding the Incident Report policy the PD said in the case of client to client aggression, an Incident Report would not need to be completed for the aggressive client if that client had a behavior program in place with data collection. However, an Incident Report should be written for the client who was the victim of the aggression, regardless of whether there was an injury at that time, because an injury could show up later.	W 104		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. 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) Client Protections. The facility failed to implement a system to monitor, track and address incidents of client to client aggression. Multiple incidents of client to client aggression were noted on behavioral data forms from January 2017 through	W 122		

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W 122	Continued From page 7 March 2017, but the facility failed to implement a system to identify the scope of the problem and how to address it. The investigation resulted in a determination of immediate jeopardy (IJ), due to concerns with clients' health and safety. The facility was notified of the IJ on 4/26/17. The IJ was removed on 5/2/17. Cross reference W149: Based on interviews and record reviews, the facility failed to implement a system to track, monitor and address incidents of client to client aggression.	W 122		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement a system to track, monitor and address incidents of client to client aggression. This affected 5 of 8 clients residing at the facility (Clients #1, #3, #4, #6 and #7). Findings follow: Record review on 4/24/17 revealed Incident Reports for the past year for the eight clients residing at the facility. The surveyor identified a minimal amount of Incident Reports provided and questioned the Program Director. For instance, there were several Incident Reports for Client #6 regarding seizures and falls from May to July 2016, but none since then. During interview on 4/24/17 at 2:30 p.m. the Program Director (PD) stated it was possible additional Incident Reports had been misplaced or possible that staff had not	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G052	A. BUILDING _____ B. WING _____	05/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-BIRCH COTTAGE	29 EAST STREET SHELBY, IA 51570

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 8 written them. She said Client #6's seizure activity had decreased recently. The Incident Reports presented on 4/24/17 contained only two incidents of peer to peer aggression: a) Client #7 hit Client #1 on 2/27/17, which did not cause an injury; b) Client #5 slapped Client #4 in the forehead on 2/06/17, with no resulting injury. Record review of Client #1's chart on 4/25/17 revealed a discharge form from the emergency room on 2/08/17 for abrasions to the face and a small laceration to the eye. According to a nursing note dated 2/09/17, Client #1 had abrasions to the right side of face caused by another client's aggression. No Incident Report regarding this incident could be located. When interviewed on 4/15/17 at 3:15 p.m. the PD stated she did not recall seeing an Incident Report for the incident on 2/08/17 when Client #1 went to the emergency room for injuries sustained as a result of aggression by Client #7. The PD noted the Program Coordinator was gone and might have additional Incident Reports in her office. When questioned about the tracking process for client to client aggression that resulted in injuries, the PD said she kept track informally on her calendar. When asked to show her 2017 calendar to the surveyor, the PD stated she had not documented any peer to peer aggressions with injuries since the first of the year. The PD said she had recently talked with staff about writing Incident Reports as needed because she felt like she was not getting as many Incident Reports as she should, including injuries of unknown origin. The PD said she had discussed this with staff at the March staff meeting. The PD was unable to produce minutes of the March meeting that showed the topic of	W 149		

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

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W 149	Continued From page 9 Incident Reports was addressed, but she did have a hand written note stating she had encouraged staff to write Incident Reports when needed. The PD provided a few additional Incident Reports on 4/25/17 at 2:50 p.m. None of the Incident Reports noted client to client aggression. The PD provided more Incident Reports on the morning and afternoon of 4/26/17. None of them noted client to client aggression, although they did document incidents of aggression toward staff, self-injurious behaviors, client injuries and one case of a client attempting to aggress toward another client. Additional record review on the afternoon of 4/26/17 revealed client behavior data sheets for Client #1 and Client #7 from January 2017 to March 2017. The behavior data sheets documented multiple incidents of client to client aggression as follows: a) On 1/06/17, Client #1 "started kicking" Client #6. There was no documentation of whether or not an injury occurred. b) On 1/20/17, Client #1 told Client #4 what to do and "started pulling on (his/her) arm." There was no documentation of whether or not and injury occurred. c) On 2/05/17, Client #1 got into an altercation with Client #7 and Client #1 bit Client #7 on his/her wrist. There was no documentation of whether or not an injury occurred. d) On 2/08/17, Client #1 got into an altercation with Client #7. Client #7 aggressed toward Client #1, who then bit Client #7. There was no documentation regarding injury to either client on the behavior form for Client #1, however the behavior form for Client #7 noted Client #1 was	W 149		

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	16G052	A. BUILDING _____ B. WING _____	05/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-BIRCH COTTAGE	29 EAST STREET SHELBY, IA 51570

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W 149	Continued From page 10 injured. e) On 3/24/17, Client #1 "started pushing peers" and threw items and hit Client #3. There was no documentation of whether an injury occurred. f) On 3/29/17, Client #1 "slapped" Client #6. There was no documentation of whether an injury occurred. g) On 3/31/17, Client #1 yelled and pushed Client #3. There was no documentation of whether there was an injury h) On 1/06/17, Client #7 "started punching" Client #6 in the chest. Regarding whether there was an injury, staff circled both the yes and no response on the form. I) On 1/09/17, Client #7 punched Client #6 in the back. Staff documented no injury. j) On 2/08/17, Client #7 aggressed toward Client #1. Staff documented injury to Client #1's face, but did not note the client went to the emergency room. k) On 2/27/17, Client #7 "started hitting" Client #1. Staff documented there was no injury. This was the only incident of client to client aggression that had a corresponding Incident Report. Further record review revealed no corresponding incident reports, no documentation of supervisory or programmatic follow up on any of the incidents of client to client aggression that did not have an Incident Report, no investigation or internal review of the incidents. When interviewed on 4/26/17 at 1:35 p.m. and asked if anyone at the agency tracked client to client aggressions, the PD said the former Qualified Intellectual Disability Professional (current Program Coordinator) might have been tracking or monitoring them, but that person was on an extended leave. The PD said the client	W 149		

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	16G062	A. BUILDING _____ B. WING _____	05/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-BIRCH COTTAGE	29 EAST STREET SHELBY, IA 51570

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W 149	Continued From page 11 monthly data summaries might indicate the frequency of client to client aggressions, however review of the monthly summaries revealed only the number of total aggressions, which included aggression toward staff. The monthly data summaries provided no information regarding client injuries caused by aggression or any changes made to the behavior programs. When interviewed on 4/26/17 at 2:30 p.m. Direct Support Professional (DSP) A said she worked at the facility for about 10 years. She said her understanding was to write an Incident Report anytime a client aggressed toward another client, regardless of whether there was an injury. She said an Incident Report should also be written if a client went to the emergency room. When interviewed on 4/26/17 at 2:40 p.m. DSP B stated she worked at the facility for about six months. She said Incident Reports were only completed for client to client aggression if one of the clients was injured. DSP B said she thought there had been discussion at a recent staff meeting regarding the need to write Incident Reports. She also recalled discussions at staff meetings regarding how to best address Client #7's behavioral issues, including aggression. When interviewed on 4/26/17 at 2:50 p.m. DSP C said she worked at the facility for almost one year. She said Incident Reports were only completed for client to client aggression if there was an injury. DSP C recalled there was discussion at a recent staff meeting reminding staff to write Incident Reports. When asked if there were any new or recent changes to Client #7's behavioral interventions, DSP C said staff just needed to keep reassuring the client when	W 149		

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	16G052	A. BUILDING _____ B. WING _____	05/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-BIRCH COTTAGE	29 EAST STREET SHELBY, IA 61570

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W 149	Continued From page 12 he/she got upset. According to the facility policy entitled Injuries, Incidents and Incident Reporting the purpose of the policy was "To ensure that individual injuries and other incidents related to individuals served, are clearly documented, promptly reported and responded to in an appropriate and timely manner." Incidents listed included peer to peer aggression. However the policy indicated that Incident Reports would not need to be completed if clients had programming in place and the incident was documented elsewhere, such as on a behavior data sheet. When interviewed on 4/17/17 at 10:10 a.m. regarding the Incident Report policy the PD said in the case of client to client aggression, an Incident Report would not need to be completed for the aggressive client if that client had a behavior program in place with data collection. However, an Incident Report should be written for the client who was the victim of the aggression, regardless of whether there was an injury at that time, because an injury could show up later.	W 149		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interviews and record review the facility failed to allow for food choices based on individual client needs and preferences. This affected 2 of 3 sample clients who had the ability to communicate their preferences (Client #1 and Client #5). Finding follows:	W 247		

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

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W 247	Continued From page 13 Observation at the day program on 4/25/17 at 11:25 a.m. revealed Client #1 unpacked his/her lunch (turkey sandwich, radishes, graham crackers, cantaloupe) and shoved all of the food away. Client #1 said he/she did not want any of the food and told staff to throw it away. A staff person took the food back to the kitchen. Client #1 asked for crackers and proceeded to eat saltine crackers and drink a glass of milk. Observation at 11:35 a.m. revealed Client #1 threw away the food in his/her lunch bag into the kitchen garbage can. The surveyor asked staff if Client #1 could have a substitute lunch. Staff offered Client #1 a jelly sandwich and the client agreed. The surveyor asked Client #1 if he/she liked peanut butter. Staff present said the facility did not allow peanut butter at the facility because it was a choking hazard. The ban was not due to any particular client, it was an agency wide practice. Client #1 said he/she liked peanut butter. When asked about it, Client #5 said he/she liked peanut butter also. Record review on 4/25/17 and 4/26/17 of the charts for Client #1 and Client #5 revealed no reason they could not have peanut butter. Both clients had general texture diets or bite sized pieces of food. The peanut butter restriction was not noted anywhere in their records. When interviewed on 4/25/17 at 3:15 p.m. the Program Director said it was her understanding that it was REM policy/practice that peanut butter was not allowed in the facilities. She said this was due to concern about peanut butter being a choking hazard. No clients were allowed to have peanut butter.	W 247		
W 322	483.460(a)(3) PHYSICIAN SERVICES	W 322		

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W 322	Continued From page 14 The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure preventative health care procedures for clients in accordance with their needs. This affected 2 of 4 sample clients (Client #1 and Client #7). Findings follow: 1. Record review on 4/25/17 revealed Client #1 (age 50) had a colonoscopy done in May, 2012. According to the follow up instructions, the physician recommended a repeat colonoscopy in three years, which would have been 2015. No further documentation regarding a second colonoscopy could be located in Client #1's chart. There was no mention of it in the client's Plan of Care dated 10/07/16. Client #1's chart also contained a medical form dated 8/08/11 regarding follow up for a hysterectomy. The form read, "No pap smear for 5 years after hysterectomy." No additional documentation could be located in the chart regarding pap/pelvic exams. There was no mention of it in Client #1's Plan of Care dated 10/07/16. When interviewed on 4/26/17 at 11:00 a.m. the facility nurse said she had worked for the facility for about nine months. She was not aware of any discussion regarding colonoscopy or pap/pelvic exam for Client #1. To her knowledge, the procedures had not been done in the past few years.	W 322		

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W 322	Continued From page 15 2. Record review on 4/26/17 revealed Client #7 was 56 years old. There was no information in Client #7's chart regarding colonoscopy or a fecal occult blood test. It was not mention on his/her annual physical or the annual Plan of Care dated 3/10/17. When interviewed on 4/27/16 at 8:45 a.m. the facility nurse said she had no knowledge of Client #7 having a fecal occult blood test or colonoscopy. She had not had a discussion about it with Client #7's physician or guardian.	W 322		
W 352	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all clients received an annual dental exam. This affected 1 of 4 sample clients (Client #1). Finding follows: Record review on 4/25/17 revealed Client #1's most recent dental exam was 12/16/15. According to the Quarterly Nursing Assessment dated 4/03/17 the nurse had unsuccessfully attempted to contact Client #1's guardian to make a dental appointment with a new provider, as the previous dentist had moved out of state. As of 4/25/17, no dental appointment was scheduled and sixteen months had passed since the last dental exam.	W 352		

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W 352	Continued From page 16 When interviewed on 4/26/17 at 11:00 a.m. the facility nurse said she had sent a release form to the guardian in September 2016, which was not returned. The nurse stated she had also reminded the guardian about signing the release during phone conversations, but the guardian was difficult to reach. The nurse reviewed her nursing notes and found an entry dated 9/12/16 indicating she had sent the dental paperwork to the guardian. No further documentation regarding contacting the guardian about a dental appointment could be located. The guardian and the nurse both attended Client #1's annual Plan of Care meeting held in October 2016, but the nurse said it didn't occur to her at that time to have the guardian sign the release for the new dentist.	W 352		

CAC 6/6/17 JKC 6/8/17

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

W102: Facility Response:
The facility QIDP with oversight from the Program Director will ensure that incidents of peer to peer aggression are monitored, tracked and addressed. The facility created and implemented a Peer to Peer Aggression Protocol which provided a general protocol for monitoring, accessing, evaluating patterns for ways to address, with the ultimate goal of creating a safer environment for individuals receiving services. Cross reference response to W104 for additional information.

Correction Date: 05/1917

W104: Facility Response:
The facility 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 (PC) had failed to consistently follow the written procedures regarding incidents and incident reporting and is no longer in the position. When a replacement PC is hired they will be trained on these expectations and will then be included in the monitoring process that these procedures will be followed appropriately. Until consistent implementation and documentation is ensured, peer to peer aggression behavior tracking sheets will be reviewed on a weekly basis by the Program Director and/or QIDP to ensure continue monitoring of these programs and to determine if revisions need to be made and to also ensure that incidents of peer to peer aggression resulting in an injury to a peer are tracked and reported in a timely matter as appropriate. The facility QIDP and PC (when hired) will monitor behavior program data monthly and report any changes, patterns, or trends to the Program Director and program revisions will be discussed and made as needed to address the reduction of peer to peer injuries and increase the overall safety for individuals receiving services.

Correction Date: 05/19/17

W122: Facility Response:
Cross reference responses to W102 and W104. In addition, revisions to two specific individual's programming for aggression were revised as the way they were written

made it appear that their data for peer to peer aggressions was artificially inflated due to combining aggression toward others, aggression toward objects and verbal aggressions all in one IPP/total number of aggressions. The Peer to Peer Aggression Protocol will be utilized to evaluate what specific steps will be utilized to address patterns of aggressions toward peers and aggressions toward peers that cause injury. These steps to address aggressions will be individually based on each individual situation and the most appropriate methods to address, reduce the aggressions and increase the safety of the living environment for individuals being served will be considered and implemented.

Correction Date: 05/19/17

W149: Facility Response:
Cross reference responses to W102, W104 and W122.

Correction Date: 05/19/17

W247: Facility Response:
The facility QIDP with oversight from the Program Director will ensure that food choices based on individual client needs and preferences are provided, which includes peanut butter. Peanut butter or other food restrictions will only be considered if there is a specific safety concern with their dietary assessment and orders and/or eating/choking hazards. Any food restrictions will be documented in the individual's dietary assessment and orders and/or other individual records. Peanut butter was made available at the time of the survey and will continue to be made available going forward. Facility staff were notified of this immediate change regarding peanut butter. The facility nurse, Program Coordinator (when hired, QIDP, and Program Director will ensure that any food restrictions are consistent with the individuals needs and are documented appropriately. At a minimum food restrictions and the dietary assessment and orders will be reviewed at least annually.

Correction Date: 06/19/17

W323: Facility Response:
The facility Program Nurse and Program Coordinator (when hired), with oversight and direction from the facility Program Director/QIDP will ensure preventative health care procedures for individuals receiving services are completed in accordance with their needs. Specific examples (i.e. pap smear, colonoscopy and/or fecal occult blood test) cited during the survey will have appointments scheduled to address the healthcare needs that were noted as deficient. Going forward the nurse will ensure that preventative healthcare is scheduled appropriately for individuals based on their needs, age and gender. This process will be reviewed with nursing 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: 06/19/17

W352: Facility Response:

The facility Program Nurse and Program Coordinator (when hired), with oversight and direction from the facility Program Director/QIDP will schedule annual dental examinations. In the example cited further attempts to obtain consent for the individual to see another dentist will be made and documented. Once guardian approval is received a dental exam will be scheduled. If dentists don't recommend annual dental examinations for individuals, on off years the nurse will conduct an annual dental health screening and document such in the individual's medical record. This process will be reviewed with nursing 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: 06/19/17
