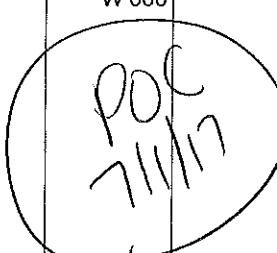


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Cal 6/6/17 8/16/17
PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/04/2017
NAME OF PROVIDER OR SUPPLIER VILLAGE NORTHWEST UNLIMITED		STREET ADDRESS, CITY, STATE, ZIP CODE 330 VILLAGE CIRCLE SHELDON, IA 51201		
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W 000	INITIAL COMMENTS The annual health survey was conducted 5/1/17 - 5/11/17. Self-reported incidents #67785-I & 67876-I were also investigated. The annual health survey resulted in deficiencies cited at W153, W214, and W369. No deficiencies were cited as a result of the investigation of self-reported incidents#67885-I & 67876-I.	W 000 		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility and staff failed to report possible abuse, neglect, and/or mistreatment to the Department of Inspections and Appeals (DIA). This affected 1 client added to the sample (Client #11). Findings follow: Review of incident reports on 5/1/17 identified a facility Incident Report, dated 4/19/17. The report described Direct Support Professional (DSP) C found Client #11 seated on the toilet in his/her room on 4/19/17 at 11:18 p.m. asleep. The report stated staff forgot Client #11 was on the toilet. DSP D assisted Client #11 to the toilet between 9:15 to 9:30 p.m. Client #11 was moved off the toilet at 11:18 p.m. and DSP C documented Client	W 153 	The Abuse and Neglect Policy has been updated to include the following statement: Intent of an act that meets the definition of abuse is not a factor to be used when determining if the act should be reported. Any act that meets the definition of abuse will be subject to the reporting process. The policy has been updated effective May 25, 2017 and will be formally approved at the June board meeting. This changed has been reviewed with the Director of ICF/ID & Program Services. The policy update was reviewed with the Residential Leaders by the Director of ICF/ID & Program Services. She will monitor and evaluate all incident reports for compliance with this policy.	5/26/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 153	<p>Continued From page 1</p> <p>#11's bottom was red where he/she sat on the toilet and right foot swollen.</p> <p>Review of Client #11's file revealed he/she had diagnoses including but not limited to: Profound to Low Severe mental retardation, mild spastic diplegia, attention deficit disorder, constipation, stable proteinuria, a ganglion cyst on his/her right wrist, and seizure disorder. Client #11 also had a history of innocent heart murmur and obstipation. Client #11 had a history of Decompress Cervical Laminectomy of C3-C5 with fusion, and was hospitalized in 2005 for Urosepsis.</p> <p>When interviewed on 5/3/17 at 2:45 p.m., Director of ICF/ID Services and Program Director confirmed staff found Client #11 on the toilet in his/her room at 11:18 on 4/19/17. She confirmed through staff interviews, Client #11 had been on the commode since 9:15-9:30 p.m. DSP D said she forgot Client #11 was on the toilet when working with other clients in the home. She further stated DSP E failed to perform an hourly bed check on Client #11. She stated this was discovered during the facility investigation. RN A assessed the following morning 4/20/17 at 8:25 a.m. and said Client #11 had no redness on both buttocks and right ankle and foot are free of edema.</p> <p>When interviewed on 5/3/17 at 2:30 p.m., the Director of ICF/ID Services and Program Director stated she didn't report the incident to the Department because there were no injuries and they did not feel the act was intentional by staff.</p> <p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must</p>	W 153		
W 214		W 214		

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W 214	<p>Continued From page 2</p> <p>identify the client's specific developmental and behavioral management needs.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the Comprehensive Functional Assessment (CFA) failed to completely and thoroughly identify the specific developmental and behavioral management needs of clients. This affected 6 of 10 sample clients (Client #1,#2,#4, #5, #6 and #7) Findings follow:</p> <p>1. Observations on 5/1/17 from 5:40 p.m. to 5:42 p.m. revealed Client #2 finished his/her evening meal. Client #2 verbally spoke and appeared upset. At 5:42 p.m. Residential Leader/Qualified Intellectual Disabilities Professional (RL/QIDP) A tried to speak to Client #2 but could not understand him/her. RL/QIDP A asked Client #2 if he/she wanted to go to his/her bedroom to talk. Client #2 did not answer her. At 5:43 p.m. Advocate A pushed Client #2 to his/her bedroom to talk.</p> <p>Observations on 5/2/17 from 7:17 a.m. to 7:29 a.m. revealed Client #2 ate breakfast. At 7:29 a.m. Client #2 spoke to RL/QIDP A. RL/QIDP A did not understand what Client #2 said, looked at another staff and shook her head no. The conversation was dropped. At 7:30 a.m. Client #2 indicated he/she was done eating after RL/QIDP A asked him/her. RL/QIDP A washed Client #2's hands and face. From 7:30 a.m. to 7:40 a.m. Client #2 took his/her dishes to the sink.</p> <p>Additional observations on 5/2/17 at 9:35 a.m. Client #2 indicated he/she did not want to listen to</p>	W 214	<p>The use of the CASAS Assessment tool will be terminated on July 1, 2017. An alternate comprehensive functional assessment tool has been developed. Staff training on use of the new comprehensive functional assessment tool will address skills in the following domains: activities of daily living, elimination, eating skills, intellectual/social, maladaptive behaviors, and health. Therapists will continue to provide evaluation and treatment recommendations for the following domains: ambulation/mobility, musculo-skeletal disabilities/paralysis, and sensorimotor skills. Ongoing compliance will be performed by the Director of ICF/ID & Program Services.</p>	7/1/17

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W 214	<p>Continued From page 3</p> <p>the story because it was sad. Staff read a newsletter then asked Client #2 if he/she wanted to play a game. At 9:37 a.m. staff placed a picture book on Client #2's tray. Client #2 used the picture book to make his/her choice of game. He/she and staff played the game.</p> <p>Observations on 5/2/17 at 11:48 a.m. Client #2 ate lunch. At 11:50 a.m. Client #2 verbally spoke to Direct Support Professional (DSP) B. She asked "Recliner?" Client #2 did not answer. DSP B stated to Client #2 she was trying. The conversation was dropped and DSP B asked Client #2 to wipe his/her face. From 11:50 a.m. to 11:58 a.m., Client #3 and staff talked about the green house. Client #2 verbally spoke, but was ignored. RL/QIDP A looked at Client #2 and asked if he/she wanted more to eat. Client #2 replied verbally, "No." From 12:00 p.m. to 12:03 p.m., Client #2 verbally spoke. DSP B said "chocolate," turned to RL/QIDP A and shook her head no. DSP B did not understand Client #2. Client #2 continued to verbally speak and DSP B continued to turn towards RL/QIDP A and shake her head no. At 12:03 p.m., Client #2 continued to speak while RL/QIDP A and DSP B picked out words. They concluded Client #2 said he/she wanted to go to work right now and told Client #2 he/she could not go to work yet, but could sit outside.</p> <p>Record review revealed the Client #2's Comprehensive Adult Student Assessment System (CASAS) dated 5/11/16, indicated skill areas, such as basic communication skills scored a "0". The CASAS failed to include a complete assessment of needed supports to communicate wants and needs.</p>	W 214		

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W 214	<p>Continued From page 4</p> <p>When interviewed on 5/3/17 at 4:10 p.m., RL/QIDP A stated Client #2 attended communication at programming, where he/she worked on building up voice muscle with vocal sounds. According to RL/QIDP A Client #2 used to have a communication device, but the device held him/her back from communicating.</p> <p>2. Record review revealed Client #1's CASAS completed 5/11/16. Skill areas, such as Grooming, Hygiene, and Health, throughout the CASAS were assessed as "0".</p> <p>3. Record review revealed the following:</p> <p>a. Client #4's Program Procedural Format (PPF), dated 7/20/16 , included a goal to decrease targeted behaviors.</p> <p>b. Client #4's CASAS, dated 5/3/16, indicated skill areas, such as Public Interaction, throughout the profile were assessed as "0."</p> <p>c. The CASA lacked a thorough assessment of targeted behaviors.</p> <p>When interviewed on 5/3/17 at 3:00 p.m., Director of ICF/ID and Program Services acknowledged the CASAS was broad and failed to contain specific assessments of skills.</p> <p>4. Observation on 5/2/17 at 11:45 a.m. revealed Client #5 filled a plastic tub with plate and eating equipment, wheeled self to the table and independently placed the items on the table.</p> <p>Record review on 5/3/17 revealed his/her CASAS identified he/she required full physical assistance/verbal modeling to complete</p>	W 214		

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W 214	<p>Continued From page 5 "table/setting place at table."</p> <p>During an interview with the Director of ICF/IID & Program Services at 3:00 p.m. she explained possibly Client #5 learned to complete this task since the assessment was completed exactly one year ago.</p> <p>5. Observation on 5/1/17 at 4:17 p.m. revealed Client #6 sat in a wheelchair and attempted to pronounce his/her name. Record review on 5/3/17 revealed a CASAS completed on 3/29/17. Client #6's CASAS indicated throughout the skill area Public Interaction, the CASAS identified a "0." Specifically for the area of "communicates first name upon request", the CASAS identified a "0."</p> <p>When interviewed on 5/3/17 at 2:00 p.m. the QIDP B confirmed Client # 6 did attempt to say own name and could not explain why there was a score of "0."</p> <p>Further observation on 5/1/17 revealed Client #6 chose chicken alfredo over a bite of lettuce, during evening meal. Record review on 5/3/17 revealed a "0" on the CASAS assessment for "can identify when given a choice between food group types."</p> <p>When interviewed on 5/3/17 at 2:00 p.m. the QIDP B explained the skill would be assessed when Client #6 viewed pictures of foods and identify the food groups.</p> <p>6. Record review on 5/3/17 revealed Client #7's PPF included targeted behaviors of non-compliance, leaving assigned area, going into peers' rooms uninvited, taking or attempting</p>	W 214		

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W 214	<p>Continued From page 6.</p> <p>to take items that do not belong to him/her.</p> <p>Review of the CASAS assessment on 5/3/17 revealed the document lacked specific assessment of targeted behaviors.</p> <p>When interviewed on 5/3/17 at 2:00 p.m. QIDP B confirmed the behaviors were in subcategories and listed as "behavioral" and "safety" concerns. She confirmed the assessment tool was not specific to Client #7's targeted behaviors.</p> <p>Record review revealed the rating scale in the CASAS included a scale of 0-4. The scale defined the level of assistance at 0 as "Does not perform at this time. The consumer does not perform the task at this time, even when given all levels of support, including full assistance."</p> <p>When interviewed on 5/3/17 at 3:00 p.m., Director of ICF/ID and Program Services acknowledged the CASAS was broad and failed to contain specific assessments of skills.</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review the facility failed to administer medication according to physician orders affecting 1 of 3 clients (Client #12) observed during medication administration in House 346. Finding follows:</p> <p>Observation on 5/2/17 at 7:00 a.m. revealed Certified Medication Aide (CMA) A administered</p>	W 214		
W 369		W 369	<p>For medications not administered bilaterally (eyes and ears), the policy and practice will be modified as follows: When medications are administered unilaterally, the route will be highlighted or documented in red on the medication administration record to emphasize and draw attention to the unilateral administration. This change was communicated to the nursing staff on 5/31/17. A memo of the change was provided to the CMS's on 5/31/17. Ongoing compliance will be monitored by the Director of ICF/ID & Program Services.</p>	5/31/17

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W 369	<p>Continued From page 7</p> <p>Pred Forte eye drop to each eye for Client #12. Review of the label revealed an order for "Pred Forte eye drop to R (right) eye 7 a.m."</p> <p>When interviewed on 5/2/17 at 7:00 a.m. CMAA confirmed she administered a drop to each eye resulting in an error.</p> <p>Record review on 5/3/17 revealed Client #12's Physician Orders dated 3/31/17. The order read, "Pred Forte eye drops 1 drop right eye at 7AM."</p> <p>Record review on 5/3/17 revealed Health Care Policies for Individuals Served by Village Northwest Unlimited, undated. The policy included a section: Safety: Accuracy is important! Always follow the "Six Rights" right medication, right dose, right time, right person, right route, right charting.</p> <p>When interviewed on 5/2/17 at 10:50 a.m. Director of ICF/ID and Program Services confirmed the CMA failed to follow the order and produced a med error for the incident.</p>	W 369		

