Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **6661**	**Fine amount reduced by 35% to $2,600.00 on October 18, 2017 pursuant to Iowa Code Section 135C.43A**		**Date:** **September 29, 2017**
Facility Name: **REM Iowa-Terry Avenue**		**Survey Dates:** **August 31, 2017 to September 7, 2017**	
Facility Address/City/State/Zip **815 Terry Avenue** **Hiawatha, IA. 52233**			
	HL	# 70578-I	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
64.60	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.** **Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.** **This rule is intended to implement Iowa Code Section 135C.2(3).**	**I**	**$4000.00**	**Upon Receipt**
W158	**483.430 FACILITY STAFFING** **The facility must ensure that specific facility staffing requirements are met.** **DESCRIPTION:** Based on interviews and record review, the facility failed to provide adequate staff training to ensure competent and knowledgeable facility staff. Facility staff failed to demonstrate knowledge of inappropriate client behaviors and corresponding behavior interventions. As a result, staff failed to ensure the safety of clients and provide adequate supervision, which attributed to the successful elopement of Client #1 from his/her home twice in approximately 30 minutes.			

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AND **W193**	Cross-reference W193: Based on interviews and record review, the facility failed to provide adequate staff training to ensure staff knowledge and competency to manage inappropriate behavior of clients. Staff failed to provide adequate supervision of clients to prevent and/or address elopement behaviors. These findings resulted in a determination of Immediate Jeopardy (IJ) due to concerns for the health and safety of clients, specifically the facility's failure to ensure appropriate supervision of clients. The facility was notified of the determination of IJ on 8/31/17 at 1:35 p.m. The facility developed and implemented a plan of abatement to provide an enhanced level of supervision, to clarify staff accountability for supervision of clients and to assure staff re-training and monitoring. The IJ was removed on 9/6/17 at 9:50 a.m. **AND** **483.430 FACILITY STAFFING** **Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.** Based on interviews and record review, the facility failed to provide adequate staff training to ensure staff knowledge and competency to manage inappropriate behavior of clients. Staff failed to provide adequate supervision of clients to prevent and/or address elopement behaviors. This affected 1 of 1 client			

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	(Client #1) identified as a result of facility self-reported incident # 70578-I. Finding follows: Record review on 8/31/17 revealed two Individual Incident Reports regarding Client #1's elopements from the facility on 8/28/17. One report noted Direct Support Professional (DSP) A noticed the front door of the home open at approximately 7:30 p.m. She questioned the whereabouts of Client #1, checked his/her bedroom, then went outside and found him/her sitting in the van in the parking lot. Staff on duty were unaware Client #1 left the home. The report also noted at 7:50 p.m., DSP B entered the home and reported he'd seen Client #1 "walking up the street." According to the report, DSP A and DSP C left the home and returned with Client #1. The second report, written by DSP B, documented his discovery of Client #1 walking down the sidewalk outside the home at approximately 7:55 p.m. DSP B wrote he drove down the street towards the home and saw Client #1 walking away from the home. He continued into the driveway of the home and noticed the back gate was open. He locked the gate, entered the home and reported what he had seen. Staff in the home failed to know Client #1's whereabouts until DSP B reported his/her elopement. Continued record review revealed Client #1's Plan of Care (POC) held on 2/3/17. Identified behavioral needs included decreasing PICA, food stealing,			

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	elopement and aggressive behaviors. The POC included an Activity Plan to display no attempts to leave the facility without staff supervision. The Interdisciplinary Team (IDT) "determined that this activity plan be revised into formal programming to properly track elopement and/or attempts to keep (Client #1) safe." The POC section related to outdoor supervision indicated Client #1 at risk for elopement and noted staff may supervise him/her through the facility windows while outside. His/Her Comprehensive Functional Assessment (CFA), initial assessment date 1/14/17, indicated he/she had no understanding of "Stranger Danger," traffic lights, street signs or how to cross the street safely. Client #1 did not understand traffic lights or respond accordingly. Client #1 did not know to cross streets at crosswalks or look for cars/and or watch for traffic signals for crossing the street. Additional record review revealed Client #1's Individual Implementation Plan (IPP) to display zero incidents of attempting to and/or eloping. The IPP directed staff to encourage Client #1 to utilize "Put Em Around" communication devices each time he/she exited the facility. The plan explained if Client #1 left the building, "staff will maintain supervision of (him/her) while (he/she) is outside." An "Additional Information" section included the following: a. Client #1 was known to walk out the facility doors and attempt to get into the facility van or staff's vehicles. b. Client #1 left the building due to being			

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	uncomfortable, agitated or bored. c. Staff should check on Client #1 every 5 minutes to ensure his whereabouts and to ensure he/she has not attempted to or eloped. Further record review revealed the facility Individual Diagnoses List. Client #1's diagnoses included severe intellectual disability, possible autism, aggressive/ noncompliant/inappropriate/over-reactive/inattentive Behaviors, disruptive behavior disorder NOS (not otherwise specified), impulse control disorder, intermittent anxiety, acid reflux, chronic constipation, rectal digging, poisoning potential (PICA), impaired verbal communication, and myopia. According to Wunderground.com, the temperature at the time of the incidents was approximately 64 degrees with clear skies and a 4.6-mile per hour (mph) wind. Observation on 9/6/17 at approximately 8:20 a.m. revealed the posted speed limit in the neighborhood of the home was 25 mph. Record review on 8/31/17 included a review of the facility staff schedule. The document listed each staff person's name and the designated group of clients each staff worked with on each day of the week. The document indicated supervision of Client #1 on 8/28/17 on second shift, fell to DSP C. Record review on 9/5/17 revealed the facility Supervision and Support Procedure. The purpose statement read, "To ensure that individuals receiving supports receive adequate support and supervision."			

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	The procedure emphasized staff could not leave an individual unsupervised unless otherwise indicated in the individual's plan of care. When interviewed on 8/31/17 at 9:15 a.m. the Quality Improvement Specialist (QIS) confirmed she conducted an investigation regarding Client #1 leaving the house twice on 8/28/17. She confirmed her investigation revealed both incidents of leaving were unobserved by staff on duty. When interviewed on 8/31/17 at 10:05 a.m., DSP C confirmed she did not see Client #1 leave the building on 8/28/17. She further confirmed she held responsibility for his/her supervision; however, she was busy assisting another client in the shower. She said she was unaware Client #1 left the building and got in the van until DSP A told her about the incident a few minutes after it occurred. Regarding the second incident, DSP C stated she checked on Client #1 in his/her bedroom and went into the laundry room across the hall to check laundry. She then went to the dining room and sat at the table doing paperwork. She recalled DSP B entered the home and stated he had just seen Client #1 walking down the street. DSP B stated she and DSP A left the home and looked for Client #1. They found him/her approximately one-half block away from the home. DSP C stated she had not received "formal training" on Client #1's needs. She said she looked in the program binder and did not see any program related to elopement. She stated she checked on Client #1 every 10 - 15 minutes, but noted he/she paced a lot that night so she saw him/her in the			

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	hallway. She said DSP D and DSP B who usually worked in the home told her they had never known Client #1 to elope. She stated staff failed to communicate with each other on the night of the incidents. When interviewed on 8/31/17 at 11:31 a.m. DSP A confirmed she typically worked at another home but agreed to work at Client #1's home on 8/28/17. She recalled she came out of the medication room and saw the outside front door open. She asked DSP B about it and he told her it was possible Client #1 stepped outside but assured her Client #1 never left the fenced in area. She checked Client #1's bedroom and did not find him/her so she went outside and found Client #1 sitting on the van at approximately 7:30 p.m. She stated they walked through the back gate to re-enter the home and she noted the back gate was closed but not locked. DSP A confirmed no staff knew the whereabouts of Client #1 prior to her finding him/her on the van. She confirmed DSP C held responsibility of supervision but explained DSP C assisted another client in the shower. She denied being asked to assume supervision of Client #1. DSP A defined Client #1's level of supervision as having eyes on him/her and recalled seeing Client #1 pace in the home prior to the incident. She noted she had no idea Client #1 had a history of elopement. She added DSP D, who worked in the home, failed to inform her and DSP C of the behavior. She recalled DSP D made lunches for the following day while in the kitchen with another client. DSP A said she and Client #1 came in the building and went to his/her bedroom where he/she			

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	laid down. DSP A said she finished administering medications and recalled seeing Client #1 pacing again. She recalled DSP D continued making lunches in the kitchen. She was unsure of DSP C's whereabouts. She stated she used the restroom and returned to the dining room where she and DSP C completed paperwork. She noted DSP B walked into the building approximately 1 - 2 minutes later and told them he had seen Client #1 walking up the street. DSP A and DSP C went outside and found Client #1 in the driveway of an apartment building approximately one-half block from his/her home. DSP A speculated the incidents occurred due to a lack of supervision and the gate being unlocked. She reiterated DSP C failed to ask anyone to take over supervision of Client #1 and DSP D's failure to inform her of Client #1's elopement behavior. She said she looked in the program binder for a program after the incident, but did not find a program for elopement behavior. She was unaware of any program to use a communication device to teach Client #1 to communicate a desire to go outside. When interviewed on 8/31/17 at 12:35 p.m. DSP D confirmed he was in the kitchen with another client on 8/28/17 when he learned Client #1 eloped. He denied any knowledge of Client #1's elopement behavior or the existence of a program to address elopement behavior. He acknowledged DSP C held responsibility for Client #1's supervision at the time of the incidents. He defined Client #1's level of supervision as 5 - 10 minute checks because he/she "gets into stuff." He confirmed both DSP A and DSP C typically worked at another home. He restated he had never seen a			

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	program for elopement but noted he received training on a program after the incidents. He noted on the night of the incident, DSP C helped a client in the shower, DSP A administered medication in the medication room and he worked in the kitchen making lunches for the next day. He commented Client #1 just "slipped away" and confirmed no one knew Client #1 left the home. He confirmed DSP C failed to ask him to supervise Client #1 while she assisted another client. When interviewed on 9/5/17 at 4:00 p.m. DSP B confirmed he drove onto the street where Client #1 lives and saw him/her on the sidewalk walking in the opposite direction of the home, unaccompanied by staff. He said he pulled in the driveway of the home and saw the back gate swinging open in the wind. He recalled another client sat on a swing in the back yard. He locked the back gate and went inside to tell the staff about Client #1's whereabouts. He recalled DSP D worked on lunches in the kitchen and DSP A and DSP C did paperwork in the dining room. DSP B stated he did not stop and direct Client #1 back to the home because he was shocked and was trying to comprehend what he had seen. DSP B confirmed Client #1 never eloped on his shift. He explained he normally worked third shift (10:00 p.m. - 6:00 a.m.) but agreed to come in at 8:00 p.m. on 8/28/17 to relieve other staff. DSP B did not know Client #1's level of supervision on second shift and stated he usually did not work second shift. He stated he checks on clients every 30 minutes on third shift. He denied being told Client #1 had an incident of leaving the building earlier			

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	in the evening. When interviewed on 8/31/17 at 10:40 a.m. the Lead DSP confirmed she was the on-call supervisor on the night of the incidents. She confirmed she received a call from DSP C, called back and spoke with DSP A. She stated she had no knowledge of Client #1's history of elopement or behavior program. She explained staff should read the individual program binder in the home to gain insight into each client's needs. She confirmed DSP A and DSP C worked at other homes and were "pulled" to Client #1's home on 8/28/17 to cover the second shift. She confirmed staff reported Client #1 left the home twice without staff knowledge. She stated she was unaware of any changes made to Client #1's program following the incidents. When interviewed on 8/31/17 at 8:40 a.m., the Program Director (PD) confirmed Client #1 eloped twice on second shift on 8/28/17. She stated staff should know Client #1's whereabouts, when asked to define his/her level of supervision. **FACILITY RESPONSE:**			

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