V 1/1/18 OK 1/9/18

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

PRINTED: 12/21/2017
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
	16G044	A. BUILDING _____ B. WING _____	C 12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-CORALVILLE	1985 HOLIDAY ROAD CORALVILLE, IA 52241

(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 At the time of investigation 72311-I and 72359-C a deficiency was cited at W249.	W 000		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to ensure clients' level of supervision was consistently followed. This affected 1 of 1 client involved in investigation 72311-I and 72359-C. Finding follows: Record review on 11/27/17 revealed a facility self-report, dated 11/14/17. The report documented Client #1's hospitalization on 11/12/17, followed by surgery on 11/13/17 due to a bowel obstruction. During surgery, it was discovered the client had ingested two latex disposable gloves. The facility staff completed an Individual Incident Report (IIR) on 11/12/17 documenting the client's condition prior to hospitalization. Facility staff also completed an IIR on 11/13/17 documenting the removal of a foreign object during surgery. Recommendation included the retraining of Client #1's PICA program.	W 249	See attached POC 12/21/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darlene Stoffa — TITLE: Regional Director — (X6) DATE: 12/29/17

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 249	Continued From page 1 Review of Mercy Hospital report, dated 11/13/17, documented the client had a high-grade small bowel obstruction resulting in surgery. The client underwent laparotomy and segmental small bowel resection due to a foreign body within the lumen of the small bowel. The surgical pathology report documented there was a 12 x 5 x 5 centimeter aggregate of dark red to black foreign material which appeared consistent with 2 latex/plastic exam gloves. Client #1 was a 21 year old with diagnoses of severe intellectual disability, autism, PICA (ingestion of inedible), constipation, incontinence, pes planus valgus, gingivitis, mixed receptive-expressive language disorder, acne vulgaris, and moderate hyperopia. Review of Client #1's Plan of Care (POC), dated 10/10/17, documented the client continued to have incidents of attempting to consume the contents of his/her brief when passing a bowel movement. The client also liked to eat things like leaves while outside, and had attempted to eat markers, nail polish, crayons and pens while doing a craft or leisure activities. The POC documented a recent program revision included staff should offer the client various sensory items to decrease PICA episodes. Client #1's Individual Program Plan (IPP), last revised on 9/28/17, addressed PICA behavior; defined as ingesting or attempting to ingest an inedible item. According to the program Client #1's access/use of personal hygiene supplies were limited due to improper use and/or health and safety concerns. Staff should redirect the client to take a break in a different area away from items he is targeting. If the client refused to	W 249		

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W 249	Continued From page 2 go to a different area, staff would provide up to two sensory items (chewy tube, keys to manipulate) to keep his/her hands occupied. If the client continued to display signal behaviors and/or attempts to ingest an inedible item, staff would use a prompting sequence including verbal prompts, blocking and removal of an unsafe item. If staff were unable to remove the item, staff should monitor to ensure the client did not choke and determine if Poison Control needed contacted. Following the incident, the program was revised on 11/24/17 to include Client #1 might target latex/non-latex gloves. Addendum to the POC, dated 11/24/17, documented "Latex would be added to targeted items. Covered, locked trash cans for disposal of preferred PICA items would be utilized at the facility and the day program. Observation on 11/18/17 at 9:00 a.m., revealed the Zone 2 garbage can in the bathroom with a lock broken off. Client #1's IPP, last revised on 9/28/17, addressing acts of elopement, documented the client's supervision level as follows: a staff person responsible for knowing the client's whereabouts will be assigned on the facility schedule. If at any time staff person would be unable to supervise Client #1, they would need to verbally ask a co-worker to assume responsibility of the client's supervision. Staff would need to get verbal verification from their co-worker they will supervise the client such as, "Yes, I will watch (Client #1)." Review of the facility Incident Investigation Overview report documented the investigation	W 249		

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W 249	Continued From page 3 dates were 11/13/17 - 11/27/17. The investigation did not provide any conclusive information regarding where or when Client #1 obtained and ingested the gloves. When interviewed on 11/27/17 at 2:00 p.m. Direct Support Professional (DSP) A stated Client #1 should never be alone unless in his/her bedroom sleeping or having private time. Since the client was very active, staff should not leave him/her alone, due to elopement behaviors. He stated gloves were in the facility, but generally behind locked doors and the client's only access would be in the shower room or the med room when he/she was with staff. DSP A stated gloves could have been in the garbage if the receptacle was not immediately emptied. When interviewed on 11/27/17 at 4:10 p.m. the Certified Medication Aide (CMA) stated Client #1 was always around staff and could not think of anytime Client #1 would have access to gloves without staff present. He had never seen the client pick up gloves or put them in his/her mouth. The CMA stated the client's supervision level could not have been followed at some time since he/she consumed gloves. The CMA stated Client #1 had vomited on 11/09/17; and on 11/10/17, Client #1 did not eat. On 11/11/17, he refused breakfast & lunch and they continued to monitor him; and later he ate applesauce and Jell-O; then had an elevated temperature. She continued to keep the On-call nurse informed of any changes as they had occurred. When interviewed on 11/28/17 at 12:30 p.m. REM Developmental Services (RDS)/DSP B stated Client #1 had to be watched closely by everyone in the day program area due to all of his/her	W 249		

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W 249	Continued From page 4	W 249		

behaviors. She stated the client was very active and if he/she left the area, staff needed to follow. DSP B stated Client #1 frequently liked to go to the drinking fountain outside of the area. Staff also escorted and stayed with the client while in the restroom. She stated she had never seen the client pick up gloves, dirty or clean or put them in his/her mouth. DSP B stated Client #1 preferred to put pens, glue sticks and markers in his/her mouth.

When interviewed on 11/28/17 at 12:40 p.m. RDS/DSP C stated one staff person would be assigned to Client #1 at RDS but all staff in the area helped to observe the client. She stated she did not feel the client consumed the gloves at RDS because he/she would have had to walk by staff to get at the garbage or box of gloves. DSP C stated Client #1 was also supervised while in the restroom. She stated she had never observed the client chew on gloves and generally would put items like pens or makers in his/her mouth.

When interviewed on 11/28/17 at 12:50 p.m. RDS/DSP D stated Client #1 should be supervised at all times and prompted to engage in activities. Staff also accompanied the client to the restroom. She stated the client had a previous incident of elopement at RDS and his/her level of supervision by staff had increased since that time. DSP D stated she had never seen the client pick up gloves and was generally interested in the craft items located in the area.

When interviewed on 11/28/17 at 1:00 p.m. RDS/DSP E stated Client #1 had an assigned staff while at RDS but all staff assisted in his/her supervision. She stated the level of supervision

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W 249	Continued From page 5 had increased since a previous elopement. DSP E had never observed Client #1 take gloves, new or used, and put them in his/her mouth. She stated she had only observed the client put food in his/her mouth. When interviewed on 11/28/17 at 1:10 p.m. RDS/DSP F stated one staff would be assigned to Client #1 at RDS. While that staff would focus on Client #1, other staff in the area assisted in his/her supervision. She stated PICA had not been a problem since the client used a specific chew item. She stated the client would steal food usually after lunch. If Client #1 would target items to put in his/her mouth, it was usually pens or makers. She had never observed the client attempt to put dirty or clean gloves to put in his/her mouth. DSP F stated the client would not have had an opportunity to take gloves, chew them and swallow at RDS without someone seeing him/her. She stated if he/she had an inappropriate item, the client was asked to throw it away. Sometimes Client #1 would look in the trash, almost like he/she was having second thoughts about throwing the item away. When interviewed on 11/28/17 at 1:20 p.m. RDS/DSP G stated Client #1 had been supervised very closely at RDS. She had never observed the client pick up dirty or clean gloves and preferred pens and makers. She further stated the client at times would steal food. When interviewed on 11/28/17 at 1:45 p.m. RDS/DSP H stated she worked at the day program as well as at the facility. She stated she only worked with Client #1 while scheduled at the facility. DSP H did not think the client had access to new or used gloves at the day program or at	W 249		

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W 249	Continued From page 6 the facility. She stated Client #1 liked to sniff items and would steal food. She had never observed the client dig in the garbage or try to get gloves. DSP H stated Client #1 was to always be closely supervised and staff should always know where the client is at. When interviewed on 11/28/17 at 2:55 p.m. DSP I stated staff were always with Client #1 while in the facility due to the client's behaviors. She stated she was unaware of any situation in which the client would have had access to gloves without staff present. DSP I stated the only time Client #1 was alone would be during private time in his/her bedroom. When interviewed on 11/29/17 at 5:35 p.m. DSP J stated Client #1 was always supervised while in the facility. She stated the client had personal time in his/her bedroom but staff would check on him/her every five minutes. Due to locks on his/her bedroom and bathroom doors, staff always accompanied the client to the bedroom/bathroom. She also had never observed the client attempt to take dirty or clean gloves and put them in his/her mouth. When interviewed on 11/29/17 at 9:25 a.m. the Lead Direct Support Professional (LDSP) stated Client #1 would always be supervised while in the central areas of the facility. She stated the only time the client was alone would be during personal time in his/her bedroom. She stated, while gloves were located throughout the facility in various areas, these areas were locked when staff were not present. Also, she had never observed Client #1 dig through the garbage or try to get gloves to chew on. The LDSP stated Client #1 generally preferred chew sticks. She	W 249		

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W 249	Continued From page 7 acknowledged staff could not have followed the client's supervision level since he/she had the time and opportunity to consume gloves. When interviewed on 11/27/17 at 12:50 p.m. the Qualified Intellectual Disability Professional confirmed staff should know Client #1's whereabouts. She did not know how the client could have gotten gloves if staff were following his/her level of supervision. When interviewed on 11/27/17 at 2:30 p.m. the Program Director (PD) stated Client #1's level of supervision was described in his/her elopement program. While they could not determine if the client consumed the gloves at the facility or REM Developmental Services, he confirmed Client #1's level of supervision was not consistently followed. The PD stated currently the facility had been trying to determine where the client had access to the gloves and had not yet identified the lack of supervision as an issue requiring retraining. When interviewed on 11/29/17 at 9:45 a.m. the Program Coordinator (PC) confirmed there had been a breakdown of Client #1's level of supervision due to the client obtaining and consuming gloves. She further stated she had been unable to determine where the client obtained the gloves since they were generally in locked areas of the facility. The PC also stated, in talking with facility staff, no one had observed the client targeting gloves. She stated Client #1 would, at times, remove one of his/her socks and chew on it. When interviewed on 11/29/17 at 11:10 a.m. the Regional Director stated the agency had been unable to determine where and when Client #1	W 249		

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W 249	Continued From page 8 obtained the gloves but assumed the gloves were either from the facility or the day program. She further acknowledged there had been a breakdown in the client's level of supervision because the client was able to consume the gloves without staff knowledge.	W 249		

1/11/18 02/14/18

Accept this plan as the facilities credible allegation of compliance.

Tag W 249: **Facility Response:** The facility QIDP, Program Supervisor (PS), Lead DSP, Program Director (PD), Quality Improvement Specialist (QIS) and Regional Director (RD) have revised and reviewed Client #1's PICA program to be more inclusive of types of items that he has attempted to consume in the past including rubber gloves; included information regarding room/environment sweeps that will be done at home, the day program and/or the community whenever Client #1 enters a new room/environment; and increased supervision expectations by checking on him at least every 5 minutes during waking hours and every 30 minutes during the overnight shift and during personal time during awake hours. We have also taken specific measures to secure plastic/rubber gloves and the garbage cans to limit Client #1's access to these items.

The facility QIDP, Program Supervisor (PS), Lead DSP, Program Director (PD) and/or day program leadership personnel has provided retraining to residential and day program staff on Client #1's PICA program. Client #1 will be transitioning to a new day program at the beginning of the year. Training with day program personnel at the new day program has already begun and on-going training will continue with the new day program. Also, to aid in the smooth transition of day programs the PS and Lead DSP will spend the first few days working alongside the new day program staff to ensure that programming implementation is followed and a safe day program environment is ensured.

Supervisors and/or designees at the residential facility and the new day program will complete programmatic observations for Client #1's PICA programming at home a minimum of twice monthly to ensure that the program is being implemented as written.

The residential and new day program leadership will also monitor supervision levels and program implementation informally when in the programs and any deviations will be addressed via on-the-spot feedback/correction. Supervisors and/or designees at the day program and/or the facility QIDP will complete programmatic observations for Client #1's programming at the day program a minimum of twice monthly to ensure that the program is being implemented as written. These observations will continue until the facility deems that they are no longer necessary at this frequency based on compliance. Programs will be reviewed monthly by the facility QIDP as part of the data summary process and will be evaluated for revisions to meet client needs. When revisions are made, staff will be trained on these revisions in both locations as applicable. Client programming will continue to be reviewed monthly at staff meetings in both locations on an on-going basis to maintain and monitor compliance.

Completion Date: 12/21/17