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 12/21/2017

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

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W 000	INITIAL COMMENTS At the time of investigation 72938-C a deficiency was cited at W125.	W 000	Please see attached.	
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to consistently ensure clients were afforded their rights to safe environment. This affected 1 of 1 client (Client #1) involved in investigation 72938-I. Finding follows: Record review on 12/18/17 revealed Client #1's Individual Incident Report (IIR), dated 12/11/17. The IIR documented Client #1 walked to (RDS) Program Supervisor's (PS) A desk at REM Developmental Services (RDS), reached behind the computer monitor and grabbed a can of Clorox disinfectant spray. The client then sprayed the disinfectant into the air and as his/her assigned staff attempted to retrieve the can from the client, he/she then sprayed the disinfectant into his/her mouth. Staff then grabbed the can from the client and redirected Client #1 back to his/her area. Poison Control was contacted and directions were followed to wipe out the client's mouth with a wet wash cloth and gave him/her 4 ounces of milk. The Program Director A (PD) informed the RDS to remove all chemicals or place all chemicals in locked cabinets. Also, staff should continue to follow and implement Client	W 125	POC 1/5/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mitch White — TITLE: PD — (X6) DATE: 1/12/18

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 125	Continued From page 1 #1's formal PICA (ingestion of inedibles) program. Record review revealed Nurse's Notes completed by the ND and dated 12/11/17 at 1:30 p.m., revealed after Client #1 managed to spray 1 second of the Clorox disinfectant spray in his/her mouth before staff stopped the client. According to the Notes, the ND received notification Client #1 had gotten hold of Clorox disinfectant spray. Poison Control was notified and instructions received to wipe out the client's mouth and flush with milk due to the client managing a one second spray into the mouth. There were no concerns for lasting toxic effects, but they were advised to watch for allergic or irritating reactions such as excessive drooling, swelling or visible mouth irritation. Assessment revealed none of the aforementioned symptoms. Record review revealed Client #1 was a 21 year old with diagnoses of severe intellectual disability, autism, PICA, constipation, incontinence, pes planus valgus, gingivitis, mixed receptive-expressive language disorder, acne vulgaris, and moderate hyperopia. Client #1's record also revealed information regarding a recent hospitalization on 11/12/17 due to a bowel obstruction as a result of ingestion of a foreign object. The obstruction was resolved surgically on 11/13/17 where two latex/non-latex gloves were removed. When interviewed on 12/18/17 at 9:30 a.m. RDS PD A stated she was notified on 12/11/17 Client #1 sprayed disinfectant in his/her mouth after taking the can off the PS A's desk. It was her understanding staff were present, but were unable to intervene quickly enough. She did not	W 125		

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W 125	Continued From page 2 know why the can of disinfectant was on the desk but at the time of the incident there was no policy in place regarding locking cleaning chemicals up. PD A assumed PS A placed the disinfectant on the desk at some time and had forgotten about it. She stated PS A sat at the desk and Direct Support Professional (DSP) A was with Client #1, but neither were able to stop the client from spraying the disinfectant into his/her mouth. PD A stated staff had been trained regarding the locked garbage cans/gloves due to Client #1's recent hospitalization/surgery for ingestion of gloves. She stated the Qualified Intellectual Disability Professional (QIDP) also trained staff on the client's PICA program after the ingestion of gloves. PD A provided the surveyor with a similar can of disinfectant labeled "Clorox Disinfecting Spray." Record review of the Safety Data Sheet of Clorox Commercial Solutions Disinfecting Spray revealed first aid measures for ingestion included drinking a glassful of water and call a doctor or poison control center. Toxicological information documented ingestion might cause central nervous system depression, gastrointestinal irritation, nausea, vomiting and diarrhea. When interviewed on 12/18/17 at 10:35 a.m. the Nursing Director (ND) stated she had been notified by PS A about Client #1's ingestion of a disinfectant. She was told by staff the client sprayed the disinfectant in his/her mouth before staff could intervene. The ND notified Poison Control and was told to wipe the client's mouth out and have him/her drink milk. Also, staff should watch for any problems such as excessive drooling, swelling or skin irritation. In her assessment and follow-up, the client did not have	W 125		

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W 125	Continued From page 3 physical problems. The ND stated she communicated to staff to lock up all chemicals and stayed in the RDS area until chemicals were secured. She also notified Client #1's Primary Care Physician. When interviewed on 12/18/17 at 9:50 a.m. RDS PS A stated she was seated at her desk on 12/11/17 after lunch, when Client #1 approached the area with DSP A. Client #1 reached around the computer monitor on her desk and grabbed a can of disinfectant. Before staff could take the can away from him/her, Client #1 sprayed some in his/her mouth. She talked to the ND and Poison Control was contacted. They were instructed to wipe out the client's mouth and give him/her milk to drink. They also instructed staff to watch out for excessive drooling, swelling or skin irritation. PS A stated they did not have a policy at the time of the incident to lock up disinfectants. She stated following the hospitalization of Client #1 for ingestion of gloves, staff were retrained on the client's PICA program. She stated Client #1 had not previously tried to access cleaning chemicals but was aware clients in other areas targeted these items. She stated cleaning chemicals in those areas were put away. PS A stated Client #1 would come to her desk at times and was interested in a scented jar on her desk. She stated she kept the can of disinfectant at her desk because it was used frequently in the area. PS A stated she felt staff followed the client's level of supervision, but was just not quick enough to intervene. She stated while there was a lot of concern regarding the securing of gloves for the client, it would have been helpful to look at what additional potential hazards existed in the area.	W 125		

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W 125	Continued From page 4 When interviewed on 12/18/17 at 10:20 a.m. DSP A stated on 12/11/17 Client #1 walked to PS A's desk as she was beside him/her. DSP A stated while she talked briefly to PS B, the client reached around the desk and grabbed a can of disinfectant and started spraying in the area and then in his/her mouth. She was able to remove the can of disinfectant from the client and redirect him/her away from the area. DSP A stated she was surprised the client even found the can of disinfectant due to being positioned behind the computer monitor. She was aware PS A contacted Poison Control and they followed instructions. Prior to the incident, Client #1 had his/her chew stick in his/her mouth and a manipulative in one of his/her hands as he/she stood by the desk rocking. DSP A stated he/she liked to stand at PS A's desk at times and was interested in a wax candle holder on her desk. She stated she had been trained about changes in securing gloves since the client's recent hospitalization. She further stated staff normally kept disinfectants locked due to the PICA behavior of another client. When interviewed on 12/18/17 at 2:50 p.m. DSP B stated cleaning chemicals were located on a cart on the other side of the room from Client #1's location. She stated they were not generally locked up, just stored on the opposite side of room from where REM Coralville clients were located. When interviewed at 12/18/17 at 2:55 p.m. PS B stated he was walking through Client #1's day program area when he observed the client spray something in his/her mouth. He asked PS A if that would hurt the client after the can of disinfectant was removed. He was aware PS A	W 125		

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W 125	Continued From page 5 contacted appropriate personal to determine if there was a problem with the disinfectant. When interviewed on 12/19/17 at 11:20 a.m. PS C stated she was notified about Client #1's ingestion of disinfectant at RDS on 12/11/17. She stated they had been in the process of revising the client's PICA program and while it had not been implemented, staff were certainly aware Client #1 needed to be closely supervised. She stated since Client #1's last incident had such serious consequences for the client, staff should have had a heightened awareness to keep the client safe. PS C stated she understood two staff were present during the incident and felt they should have been able to intervene. She further stated, at home, chemicals were kept behind locked doors to ensure client safety. When interviewed on 12/19/17 at 1:00 p.m. PD B stated he was notified about Client #1's ingestion of disinfectant at RDS on 12/11/17. Client #1's Interdisciplinary Team had been working on program revisions to his/her PICA program, but not all changes had been finalized at the time of the incident. He stated the team discussed using targeted items and intervention strategies when at the facility and RDS to ensure the safety of the client. He felt they had covered all areas of concern but was unaware the client would have access to chemicals at RDS or would target items on PS A's desk. He stated staff should have been on high alert regarding Client #1's supervision due to his/her recent major incident of PICA behavior. PD A stated it was the agency's responsibility to keep client's safe and acknowledged Client #1's safety had not been ensured.	W 125		

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W 125	Continued From page 6 Record review on 12/19/17 revealed The Mentor Network Individual Rights Statement, Rights Afforded to Adults in All the Mentor Network Programs last updated on 6/1/16. The list of rights included, but was not limited to "Being treated with respect and dignity as a human being" and "The right to a safe... living environment." Record review also revealed "REM Iowa Quality of Care Standards." The document stated, "Every individual receiving services, regardless of age, complexity of condition, service type, or setting in which the services are provided, can expect:... Personal safety - safety and security in home and community." When interviewed on 12/19/17 at 3:05 p.m. the Regional Director (RD) stated she had been notified about Client #1's incident in which he/she sprayed disinfectant in his/her mouth. She stated the decision was made to have the client remain in the facility and not attend RDS since the client would be attending a new day program after the first of the year. Client #1 had a recent issue with consumption of disposable gloves and new procedures had been put in place to secure gloves and locked garbage containers. Facility and RDS staff also had retraining of programming and discussion about strategies to keep Client #1 safe. The RD stated there had been team meetings in which Client #1's behaviors were discussed and recommendations were made for program revisions to include more specifically the client's targeted items during PICA behavior. While ingestion of cleaning chemicals had not been a previous issue for Client #1, staff were aware the client could ingest items not typically targeted as experienced when he/she consumed	W 125		

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W 125	Continued From page 7 the disposable gloves. She stated staff had an increase awareness of the need to closely supervise Client #1 due to PICA behaviors. The RD stated it was her understanding in the ICF/ID programs; chemicals should be locked up but was aware in the other Day Habilitation programs operated by REM cleaning chemicals were not locked up. She was unsure why the disinfectant would have been left unlocked as clients in other areas of RDS also have PICA issues and have targeted cleaning supplies. She acknowledged Client #1's environment and interactions by staff at the time of incident did not ensure his/her safety.	W 125		

✓ 1/23/18 OK 1/19/18

Tag W 125: Facility Response:

The facility QIDP, Program Supervisor/QIDP, Lead DSP and/or Program Director/QIDP will ensure the rights of all clients are protected, particularly in regards to ensuring a safe environment. Client # 1 was immediately removed from services at the Hiawatha RDS location, per guardian request, following the incident on 12/11/17. Immediately following the incident on 12/11/17, staff at both RDS and Client # 1's home were retrained on locking all chemicals to restrict access to individuals, unless directly supervised in their use. Household chemicals were added to Client # 1's PICA programming and staff at home were retrained accordingly.

Effective 01/03/18, Client # 1 began attending day programming at WCDC Inc., in Washington, IA. Prior to Client # 1 attending WCDC, staff were trained extensively on his PICA programming, in addition to his other programming. WCDC staff were trained on locking chemicals to restrict unsupervised access by individuals. Other measures (i.e. secured gloves, wipes, garbage cans, etc.) to ensure Client # 1's safety while attending the day program were also implemented before his attendance at WCDC. In addition, the QIDP, Program Supervisor and Lead DSP worked alongside the WCDC staff for the first three days that Client # 1 and his peers attended the new day program. This transition planning was to ensure that the individuals were comfortable in their new day program; WCDC staff and supervisors had the opportunity to ask questions directly and in the moment; to ensure accurate program implementation; and ensure that the environment was maintained to ensure safety per individual programming specifications.

Going forward, the Program Director/QIDP, Program Supervisor/QIDP, and facility QIDP will ensure these safety measures remain in place and staff will be retrained on any changes to Client # 1's PICA programming. Supervisors and/or designees at the residential program will complete Programmatic Observations for all clients at home and at the vocational program at least semimonthly to ensure that all clients' programming is being implemented as written and any potential unsafe environmental concerns are addressed on the spot and modifications will be made to correct the issue, as well as provide any staff feedback as needed. These observations will continue until the facility deems that they are no longer necessary at this frequency. In addition, leadership personnel will be mindful of ensuring safe home and day program environments any time when they are in the programs and will provide on the spot feedback and correction to ensure safety.

Completion Date: 01/05/2018