V 6/21/18 ok 6/19/18

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

PRINTED: 06/08/2018
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
	16G059	A. BUILDING _____ B. WING _____	C 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND DRIVE GROUP HOME	202 HIGHLAND DRIVE CEDAR FALLS, IA 50613

(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 As a result of investigation of #75547-I 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 staff failed to report client supervision over to another staff, which resulted in a client left at the facility alone, unsupervised for an hour and fifteen minutes. This affected one of one client (Client #1). Finding follows: The facility Internal Investigation, initiated 4/16/18 indicated at approximately 9:35 a.m. the Qualified Intellectual Disabilities Professional (QIDP) received a phone call from Licensed Practical Nurse (LPN) A concerned there was no staff at the facility with Client #1. The QIDP contacted the On-Call Administrator from the weekend who confirmed she had not been able to find a staff to stay at the facility with Client #1, who stayed home sick on 4/16/18. The QIDP arrived at the facility at 9:45 a.m. to find Client #1 asleep in her	W 249	See attached POC 6/12/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: CW Repp — TITLE: Program Director — (X6) DATE: 6/12/18

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 249	Continued From page 1	W 249		

bed and no staff present. Client #1 was alone at the facility from approximately 8:30 a.m. until the QIDP arrived at 9:45 a.m. A nursing assessment was completed with no injuries noted.

Additional record review revealed Client #1 was 31 years old and had resided at the facility since 1999. She had diagnoses including: but limited to: severe intellectual disabilities, autism, apraxia of speech, and hearing deficits. Client #1 had a behavior program in place to address target behaviors of aggression (hitting, pushing/shoving, grabbing, kicking, biting, pinching, and pulling hair). Restrictive measures utilized included the use of behavior modifying medications (Buspar and Haldol).

Review of Client #1's Individual Program Plan (IPP), dated 1/18/18, instructed Client #1 was to be supervised at all times in the residential area and closely supervised around peers due to aggressive behaviors.

Continued record review revealed the following:
a. An incident report, dated 4/15/18 at 8:26 a.m. completed due to vomiting.

b. Client #1's daily log included an entry from 4/15/18 at 8:01 p.m., which noted Client #1 had two emesis overnight and a third during medication administration.

c. Client #1's daily log included an entry from 4/15/18 at 8:00 p.m., which noted DSS reported a vomiting incident and instructed Client #1 be taken to the emergency room (ER) for evaluation.

d. Client #1's daily log included an entry from 4/15/18 at 8:51 p.m. According to the log, Client

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W 249	Continued From page 2 #1 was seen in the ER due to vomiting. The client received an IV, chest x-ray, and CT scan. The CT scan revealed enlargement of the gallbladder but not stones or irritation, as well as mild fluid distention of the stomach and probably bilateral renal cysts. The ER nurse reported all labs looked good a no concerns were noted. Client #1 was discharged from the ER with instructions to see his/her physician in 1-2 days and receive an ultrasound of the gallbladder if the physician agreed. Client #1 was ordered clear liquids for the next 12 hours, followed by slow advance of the BRAT (bananas, rice, applesauce, and toast) diet. Client #1 also received a prescription for to be administered as needed for nausea/vomiting. Upon return to the home, the client was very tired and went to bed after receiving HS medications. The nurse instructed staff to offer sips of pedialyte frequently to prevent dehydration. When interviewed on 5/15/18 at 11:30 a.m., the QIDP said she went to the facility the morning of 4/16/18. Things were going fine and she left to attend to other tasks. The QIDP stated at approximately 9:35 a.m. she received a phone call from LPN A concerned no one was at the facility with Client #1. The QIDP explained LPN A and another staff had left the facility at approximately 8:30 a.m. to take another client on an appointment when LPN A called her during the transport. The QIDP stated she immediately called the On-Call Administrator (OCA) from the weekend to ask what staff was to work at the facility with Client #. The OCA informed her she was not able to find anyone to work. She stated she immediately hung up the phone, went to the facility, and found Client #1 sound asleep in her bed. The QIDP stated she arrived at 9:45 a.m.	W 249		

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W 249	Continued From page 3 The QIDP stated she assisted Client #1 to use the restroom. Registered Nurse (RN) A arrived approximately five minutes later and completed a head to toe assessment of Client #1, who had no injuries. The QIDP explained when a client stayed home and staff coverage was not able to be found either the primary nurse of the QIDP would stay with the client until either staff could be pulled from another location or until a staff person could come in. It had not been communicated coverage was needed. The QIDP confirmed Client #1 required staff supervision and had no facility alone time per his/her IPP. When Interviewed on 5/14/18 at 12:05 p.m., the OCA explained on 4/15/18 Client #1 had been sick, was seen at the Emergency Room, and was to stay home on 4/16/18. She stated she attempted to find a staff to work at the facility with Client #1 on 4/16/18 but had not been able to find anyone to work. She stated nothing else happened until 4/16/18 at approximately 9:30 a.m. when the QIDP called her to find out who was supposed to work at the facility with Client #1. The OCA said she informed the QIDP she was unable to find anyone and the QIDP stated she would go to the facility. The OCA stated when she arrived to work at 12:00 p.m. she was informed Client #1 had been left alone at the facility. The OCA confirmed Client #1 was to receive 24-hour staff supervision. When interviewed on 5/15/18 at 8:05 a.m., Direct Support Staff (DSS) A stated she worked on 4/16/18 on first shift. She stated Client #1 had been sick on 4/15/18 and was to stay home from Day Program on 4/16/18. DSS A said DSS C was Client #1's assigned staff on 4/16/18. DSS A stated one of the other staff working stated there	W 249		

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W 249	Continued From page 4 would be another staff coming in to stay with Client #1, but could not recall who stated this. DSS A said LPN A and DSS B were at the facility when she left her shift with DSS C on 4/16/18. DSS A did not know if DSS C had reported Client #1 over to another staff prior to leaving her shift. When interviewed on 5/15/18 at 8:25 a.m., DSS B stated she worked first shift on 4/16/18 with DSS A and DSS C. She said at about 7:00 a.m. she asked DSS C, Client #1's assigned staff, if Client #1 was staying home since she had been sick and who was staying with her. DSS B said DSS C told her Client #1 was staying home but was unsure who would be staying at the facility with her. DSS B said she went back to assisting her clients until they left for the Day Program. DSS B stated LPN A and the DSS D were in the basement of the facility when she left her shift at 8:15 a.m. When interviewed on 5/15/18 at 9:05 a.m., DSS D reported on 4/16/18 she arrived at the facility at approximately 8:00 a.m. to assist another client on an appointment with LPN A. She said they had to leave the facility by 8:30 a.m. so DSS A assisted her to load the client onto the van where she and the client waited for LPN A. DSS D stated as they waited she observed DSS B leave the facility at approximately 8:17 a.m. and then saw DSS A and DSS C leave a few minutes later. DSS D stated at 8:30 a.m., LPN A got onto the van and they left for the appointment. DSS D said about an hour into the drive she asked LPN A what was wrong with Client #1 and told LPN A about being asked if she could stay with Client #1 today. DSS D reported LPN A immediately picked up her phone and asked her if she seen any staff show up at the facility. DSS D stated she told	W 249		

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W 249	Continued From page 5 LPN A she saw all the staff leave but did not see any staff arrive at the facility. DSS D said LPN A called the facility and no one answered then LPN A immediately called the QIDP and reported concerns Client #1 was at the facility without staff. DSS D stated after LPN A reported to the QIDP she called RN A and asked she go complete a nursing assessment on Client #1. DSS D confirmed Client #1 should have 3-5 minute checks and has no facility alone time. When interviewed on 5/15/18 at 9:45 a.m., LPN A stated she worked on 4/16/18. She said she completed medication pass then went to finish charting in the basement before attending an appointment with another client in the facility and DSS D. She said around 8:20 a.m. she went back upstairs and all the lights in the facility were off, she got her things, and left the facility to go on the appointment. LPN A stated between 9:15 a.m. and 9:30 a.m., DSS D had asked about Client #1 when she realized she had not seen any staff arrive so immediately called the QIDP and reported the concerns Client #1 was alone at the facility. LPN A said the QIDP called the OCA on speakerphone and she could hear the OCA say she was not able to find a staff to stay at the facility with Client #1. LPN A stated she called RN A and asked her to go complete a head to toe assessment of Client #1. LPN A stated she was informed when the QIDP arrived Client #1 was asleep in bed. LPN A confirmed Client #1 was to be checked on every 3-5 minutes when awake and checked every two hours if sleeping. Attempts to interview DSS C were unsuccessful. A review of DSS C's statement to the facility revealed the following: DSS C had accountability for Client #1 on 4/16/18. DSS C last assisted	W 249		

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W 249	Continued From page 6 Client #1 at approximately 8:00 a.m. when Client #1 drank some Pedialyte and then Client #1 went back to bed. According to the document, DSS C said LPN A was in the basement and AS was on the van preparing to take another client on an appointment. DSS C said she thought LPN A was going to stay with Client #1 but had not said anything to LPN A about Client #1 prior to leaving her shift. DSS C said LPN A had to have heard the staff clock out and she thought she maybe said something like "have a good day" before leaving. Review of facility policy "Supervision Responsibilities of Direct Support Staff," last revised 8/7/15, instructed "Individuals who required 24 hour supervision should never be left in the home unsupervised."	W 249		

OK 6/19/18

✓ 6/21/18

Highland Plan of correction from investigation May 14-17, 2018

TAG 249 Program plan implementation

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.

The facility will ensure that individuals are supervised per their program plan and communication is occurring when shift change happens. When individuals have to stay home the person filling shift will communicate directly with supervisor or nurse to ensure needs are met. All appropriate staff have been trained .

Program Director, QIDP, Manager's, Nurses and Director of Nursing to monitor through initial and annual training of policy Supervision Responsibilities of Direct Support Staff.

Date of completion: 6/12/18