✓ 9/24/18 OK 9/20/18

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

PRINTED: 08/20/2018
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
	16G052	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-BIRCH COTTAGE	29 EAST STREET SHELBY, IA 51570

(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 the result of the investigation of #76545-M and #76549-M, a deficiency was cited at W153.	W 000	please see attached.	
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) 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 interview and record review, the facility failed to ensure allegations of abuse were immediately reported. This affected 2 of 2 clients involved in abuse investigations (Client #1 and Client #2). Findings follow: Review of the facility investigation on 7/18/18 revealed Direct Support Professional (DSP) B witnessed DSP A push Client #1 on his shoulder, causing the client to stumbled backwards, after Client #1 purposefully coughed near DSP A's face. This incident happened around 5:00 p.m. on 6/07/18. DSP C witnessed DSP A push Client #1 on his chest on 6/07/18 at approximately 8:00 p.m., causing the Client #1 to stumble backwards against the couch. DSP B and C discussed the incidents, but did not report it until the next afternoon. The facility began an investigation on the afternoon of 6/08/18. When the facility interviewed DSP D, he said he had seen DSP A curse and yell at clients and treat them like "trash." DSP D said he had seen DSP A push/shove Client #1 on multiple occasions. DSP	W 153	POC 8/20/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] | PO | 08/29/18

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 153	Continued From page 1	W 153		

D also reported he witnessed DSP A send Client #2 to her room for refusing to shower. He said on the afternoon of 6/08/18, DSP A said to Client #2, "You f***ing stink" and sent the client to her room. Client #2 became upset and hit herself in the head. DSP E also said she had heard DSP A tell Client #2 that she stunk and told her to go to her room. DSP E said she regularly witnessed DSP A yell and curse at clients, especially at Client #1 and Client #2.

When interviewed on 7/17/18 at 3:45 p.m. DSP B said she and DSP C went to Birch House on the afternoon of 6/07/18 around 5:00 p.m. to check in medications. DSP B said she stepped out of the medication room door because she heard something. She looked down the hallway and saw DSP A standing near the kitchen door. Client #1 was close to DSP A and leaned in and coughed near her face. DSP A pushed Client #1 with one hand on his right shoulder. Client #1 stumbled back but did not fall. DSP B went back into the medication room and told DSP C about the incident. DSP B said she did not report the incident immediately to management staff because she wanted to talk to a management staff face to face to discuss it. DSP B said she heard DSP A yell at clients in the past, but she had not witnessed DSP A send a client to their room or curse at clients. DSP B usually worked at the group home next door.

When interviewed on 7/17/18 at 3:00 p.m. DSP C said she and DSP B went to Birch House on the afternoon of 6/07/18 around 5:00 p.m. to check in medications. DSP B left the medication room briefly and then came back in and said she had just seen DSP A push Client #1. DSP C went back to Birch House on 6/07/18 around 8:00 p.m.

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W 153	Continued From page 2 to pass medications. She had passed some of the medication and walked part way down the hallway to find another client who was ready for medications. From the hallway, DSP C saw DSP A sitting on the couch in the living room. Client #1 was standing behind DSP A, when he leaned over and coughed near DSP A's face. DSP A got up and began to go around the back of the couch. Client #1 again leaned in and coughed near DSP A's face. DSP A used a flat open hand and pushed on Client #1's chest to push him back. Client #1 stumbled backwards into the back of the couch. DSP C said she and DSP B reported the allegations the next day, shortly after they arrived for their shift at 2:30 p.m. DSP C said she had not seen DSP A tell Client #2 to go to her room, but she had noticed on a past occasion that Client #2 would not come out of her room after DSP A had gone to her room to talk to her. This was unusual since Client #2 was typically sociable and liked to be in the common area with others. DSP C said she mentioned this to the Lead DSP at the Aspen House, where DSP C usually worked. DSP C said it seemed odd that Client #2 did not come out of her room. When interviewed on 7/18/18 at 1:20 p.m. DSP D said DSP A regularly yelled and cursed at clients. on the afternoon of 6/18/18, Client #2 was refusing to shower. DSP A told the client, "You f***ing stink". DSP A told Client #2 she could not sit in the living room with the rest of the group and she needed to go to her room. Client #1 began hitting herself in the head. DSP D said he witnessed DSP A on multiple occasions send Client #2 for refusing to shower. DSP D said he did not see DSP A push Client #1 on 6/07/18, but he had seen her do it multiple other times when Client #1 was aggressive or coughed in DSP A's	W 153		

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W 153	Continued From page 3 face. DSP D said DSP A pushed Client #1 away with force and this happened frequently. DSP D never saw Client #1 fall or get injured from the pushes. DSP D said he had reported concerns about DSP A to the Program Coordinator and the Program Supervisor in the past. When interviewed on 7/18/18 at 3:00 p.m. DSP E said she witnessed DSP A yell and scream at the clients. She had also seen DSP A tell Client #2 to go to her room when the client refused to shower. Client #2 sometimes reacted by hitting herself in the head or biting herself. Sometimes Client #2 also cried when sent to her room. DSP A yelled at Client #2 if she tried to come out of her room after DSP A had sent her there. DSP A seemed to target Client #1, #2 and #3. DSP A yelled at Client #3, but the client was hard of hearing. DSP E had never seen DSP A push Client #1, just yell and scream at him. When interviewed on 7/18/18 at 1:00 p.m. the Program Supervisor said no staff person had made allegations that DSP A mistreated or abused clients prior to the afternoon of 6/08/18. When interviewed on 7/18/18 at 2:00 p.m. the Program Director acknowledged the staff should have reported the allegations of client mistreatment/ abuse immediately. She said she first learned of the abuse allegations on 6/08/18. Staff had complained about DSP A in the past, but not related to mistreating clients. According to the facility Abuse Reporting Policy, an employee who observes or suspects abuse, neglect or potential abusive acts should immediately make a verbal report to the person in charge (supervisory or management staff). A	W 153		

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W 153	Continued From page 4 supervisor who receives such a report should immediately report the allegation to the program director or designee. Once the report is received, the facility would separate the alleged perpetrator from the alleged victim.	W 153		

OK 9/20/18

Accept this plan as the facility's credible plan of compliance

W153: Facility Response:

The facility Program Supervisor and/or QIDP, with oversight from the Program Director, will ensure allegations of abuse are reported immediately. If a supervisor is unavailable to make an immediate report to, the employee who is making the allegation will notify the supervisor on-call so that the alleged victim can be separated from the alleged perpetrator as quickly as possible and an investigation into the allegation can begin. Staff received training on the abuse reporting policy at a facility staff meeting on August 9, 2018 and this will remain a standing item to be reviewed at monthly staff meetings. To ensure a system level change, all newly hired employees are provided a formal, approved abuse reporting training and this training is offered to current employees every two years. Specific personnel follow up with be provided to any employee who does not follow our Abuse/Neglect Reporting, Investigation and Follow Through procedure.

Correction Date: 08/20/18