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

PRINTED: 12/20/2018
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
	16G035	A. BUILDING _____ B. WING _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-EIGHTH STREET	3025 EIGHTH STREET MARION, IA 52302

(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 #79601-I, a deficiency was cited at W189.	W 000	POC 12/11/18 Please See attached.	
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure staff effectively and competently performed job duties as established in the agency's standard of care. Staff failed to ensure keys to the facility were secured and the bathroom/bedroom doors were closed. As a result, Client #1 was found alone with Client #2 in the bathroom exhibiting precursor behaviors to a sexual act. This affected 2 of 2 clients involved in investigation 79601-I. Finding follows: Record review on 11/7/18 revealed a facility Incident Investigation Overview completed on 10/19/18. The report documented on 10/12/18 at approximately 7:55 p.m. Direct Support Professional (DSP) A entered Client #2's bathroom and found Client #1 in the bathroom on his knees with his pants and underwear down, holding his erect penis a few inches from Client #2's unclothed bottom. DSP A called for assistance and Client #1 was directed out of the restroom by DSP B. A nurse was notified and assessments were completed on both clients. No injuries were documented. The report noted	W 189		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gail M. Siddell | TITLE: Program Director | (X6) DATE: 12/28/2018

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 189	Continued From page 1 Client #1 had previous incidents of targeting Client #2 and had been found in similar situations on 8/23/15, 9/6/15 and 3/28/16. During the investigation, Client #1 was given a key to open a locked door. The client was able to open the door however took him several minutes to complete. In addition, Individual Incident Reports were completed for Client #1 and Client #2 on 10/12/18. As follow-up to the situation, an alarm was added to Client #2's bedroom door to ensure the client's privacy. Record review included the following information: Client #1 was 30 years old with diagnoses including: moderate intellectual disability, cerebral palsy and bilateral finger contractures. Client #1 ambulated independently and possessed some basic verbal communication skills. The client's Comprehensive Functional Assessment (CFA) last updated on 6/21/18 documented the client had basic knowledge of body parts, but no basic knowledge of intercourse or consent. Client #2 was 27 years old with diagnoses including profound intellectual disability, cerebral palsy, self-injurious behaviors, cortical blindness, developmental delay and aggressive behaviors. The client required assistance of one staff to ambulate and communicated using vocalizations. The client's CFA last updated on 3/17/18 documented the client had no knowledge of body parts, intercourse, or consent. Record review revealed at the time of the incident on 10/12/18, Client #1's Individual Program Plan to reduce acts of inappropriate sexual behavior	W 189		

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W 189	Continued From page 2 last been revised on 7/1/18. The plan stated at the beginning of each shift, staff should ensure Client #1's bedroom and bathroom doors were closed and test the alarms on each door to ensure they sounded when opened. If the alarm sounded, staff should use their key to reset the alarms on his bedroom and/or bathroom door. The program also identified Client #1's history of targeting Client #2 and documented prior incidents occurred on the overnight shift and during the early morning hours. Staff should be aware if the client recently had a haircut and/or family visits due to behaviors exhibited following these events. Client #1's record documented outings with family members on 10/5/18 and 10/11/18. Additional record review revealed a training sheet, initiated 10/16/18, documented a door alarm installed on Client #2's bedroom door which sounded any time the door opened and would continue to sound until the door closed. Staff were also to ensure Client #2's bedroom door with an automatic lock was kept closed at all times. The door would remain locked until unlocked with a key. The form documented Client #2 preferred to have his bedroom door closed and would assist with that. Staff were to also ensure Client #2's bathroom doors were kept closed and locked. Staff were to keep all staff keys locked up or carried on them at all times. Observations of the home on 11/7/18 revealed Client #1's bedroom door and door leading to the adjoining bathroom had door alarms, which were turned on and off with a key. Client #2's bathroom adjoined to another client's bedroom. Client #2's bedroom door and door leading from the adjoining bathroom to Client #2's bedroom locked	W 189		

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W 189	Continued From page 3 automatically when shut. The bedroom door could not be opened from the outside. The bathroom door could be not be opened from inside the bathroom but could be accessed from Client #2's bedroom. In addition, observation of the staff key rings revealed eight keys on the staffs' lanyards. One of the eight keys opened the bedroom doors. Due to the unavailability of DSP A, the written summary of her interview with the facility investigator provided the following information: On 10/12/18 DSP A was in the bedroom next door to Client #2 assisting another client with personal needs. She walked into the shared bathroom where she observed the client on the toilet, naked, which was common when Client #2 used the restroom. She exited the restroom and continued to assist another client for approximately five minutes when she again entered the shared restroom. She observed Client #2 lying on the floor on his back in a fetal position. Client #1 was on his knees with his shirt on, pants and underwear were pulled down. Client #1 had one hand on the floor stabilizing himself and the other hand holding his erect penis. She observed Client #1 was inches away from Client #2's unclothed bottom. DSP A called for assistance. Client #1 immediately stood up and pulled up his pants. Her co-workers, DSP B and Certified Medication Aide/Lead Direct Support Professional (CMA/LDSP) A, came into the restroom, entering through Client #2's bedroom. DSP B assisted Client #1 out of the area while she assisted Client #2. DSP A indicated she did not know if Client #2's bathroom or bedroom door were open or closed prior to the incident. No injuries were observed. After the incident, she observed a set of keys hanging in	W 189		

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W 189	Continued From page 4 Client #2's bedroom door however never observed keys in the restroom or on Client #1. When interviewed on 11/7/18 at 2:15 p.m. DSP B stated he worked 2nd shift on 10/12/18. After supper, he assisted Client #2 to the restroom after undressing him. He stated the client preferred to sit on the toilet, naked, and would put pajamas on after using the restroom. He recalled, when leaving the client's bathroom, both bathroom doors were shut, and he also closed Client #2's bedroom door. DSP B stated he helped a client in the laundry room, which was directly across from Client #2's bedroom. He then went down the hallway to assist another client with personal needs when he heard DSP A call for help. He went to Client #2's bedroom, and observed the door was open as well as the bathroom door. Client #2 laid on the floor on his back, with his hands folded and legs pulled up. Client #1 stood over Client #2 fully clothed with a set of keys in his hand. DSP B stated he walked Client #1 out of the area to his bedroom. He also noted Client #1 was drooling a lot as he stood over Client #2. He never observed Client #1 touch Client #2 and did not know what the client's intentions were. DSP B stated he tried to talk to Client #1 about the situation but the client hung his head. DSP B stated he had seen Client #1 in the dining room about five to seven minutes earlier sweeping the floor. He was unable to explain how the client obtained the set of keys because he said staff should always have keys on them. DSP B stated he knew he had his set of keys because they were in his hand when he returned to Client #2's bedroom when staff called for assistance. Before supper, DSP B stated he observed Client #1 with a single key in his hand standing between a closet and Client #2's	W 189		

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W 189	Continued From page 5 bedroom door attempting to put the key in the bedroom door lock. DSP B asked the client for the key and put the key away. Before putting it away, he noticed the key was bent and did not know what it opened. DSP B stated he was aware of the sexual issues with Client #1 and targeting Client #2. When interviewed on 11/13/18 at 1:00 p.m. CMA/LDSP A stated she came to the facility on 10/12/18 sometime after 6:00 p.m. to administer medications to clients. She started her medication pass after 7:00 p.m. and recalled Client #1 was following her. She redirected the client to the dining room area where DSP B sat. She could not recall if the client sat down with staff but knew he was in the dining room area. At the time she heard DSP A call for assistance, she was in the medication room with a client. She immediately left the medication room, walked into Client #2's bedroom through an open door and into the bathroom, which was also open. She stated DSP B was ahead of her and observed keys hanging from the lock on Client #2's bedroom door. When she walked into the bathroom, she observed Client #2 lying on the floor, naked, with legs drawn and hands to body. Client #1 stood over him, with underwear on and pants down. She did not observe any physical contact between clients and did not see any injuries. She notified appropriate staff and nursing completed an assessment on both clients. CMA/LDSP A stated, in her experience at the facility, staff carried facility keys on them. They also kept the doors to the bathroom/bedrooms shut due to past incidents involving Client #1 and Client #2. Client #2 also had alarms on his bedroom and bathroom door. CMA/LDSP A stated she never observed any	W 189		

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W 189	Continued From page 6 keys out in the central areas of the facility when she arrived at the facility. She stated she did not know where the keys came from or how Client #1 would have access to them. CMA/LDSP A stated she did not use a set of facility keys while working on 10/12/18. When interviewed on 11/13/18 at 2:05 p.m. DSP C stated staff were instructed to ensure Client #2's bedroom and bathroom doors were shut when the client was in there. Staff were also to keep facility keys on their person and check the alarms on Client #1's bedroom/bathroom door. He stated for Client #1 to have access to keys, staff would have had to leave the keys available or left in a client's door. When interviewed on 11/14/18 at 9:30 a.m. DSP D stated staff were trained to carry keys to the facility with them, keep Client #2's bedroom door shut especially when he was in there and check Client #1's door alarms. She said these measures were put in place due to past issues of Client #1 targeting Client #2. When interviewed on 11/14/18 at 2:55 p.m. LDSP B stated staff were trained to keep client bedroom and bathroom doors shut and to carry facility keys on them. She stated these measures were put in place due to past issues between Client #1 and Client #2 even though she had not observed any recent issues. She stated Client #1 also had alarms on his bedroom/bathroom door as a part of the preventative measures and staff were trained to check these alarms as well. When interviewed on 11/7/18 at 3:25 p.m. the Qualified Intellectual Disability Professional stated staff were trained to keep facility keys with them	W 189		

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W 189	Continued From page 7 and to keep bedroom/bathroom doors shut. When interviewed on 11/7/18 at 1:15 p.m. the Program Director (PD) stated as a result of the investigation involving possible sexual contact between Client #1 and Client #1, an alarm was placed on Client #2's bedroom door and Client #1 would also be moving to another facility within the agency. The PD stated the two possibilities which could have occurred were: the door could have been left open or the staff keys were available to access the bedroom. She stated normally staff kept keys on their person or locked in the staff closet and clients would not typically have access to staff keys. Additional interview on 11/14/18 at 11:40 a.m. the PD confirmed facility staff failed to follow Client #1's programming and training by either not securing the facility keys or ensuring the bathroom/bedroom doors were closed as necessary. On 11/15/18 at 1:00 p.m. the PD verified the information covered on the training sheet 910/16/18) covered staff expectations at the time of the incident. She acknowledged these expectations were not followed; either the client had access to staff keys or the doors were left open.	W 189		

✓3/22/19 OK 3/28/19

Accept this plan as the facilities credible allegation of compliance.

Tag W 189: **Facility Response:** In relation to the incident investigation, DSPs A & B who were involved in the situation investigated are no longer working for the agency. Client #1 has moved out of the facility and into a different facility within the agency. Systematically, all staff at the facility will sign a training sheet indicating that they will watch for signs of sexual attraction between any of the other clients within the current group of clients who now reside in the facility. The training sheet will inform staff that if they notice any signs of sexual attraction between any clients they will report this to the facility Program Supervisor, Lead Direct Support Professional, QIDP, Program Director, or designee no later than the following day after noticing signs of attraction so that specific precautions based on the clients involved can then be put in place in order to attempt to prevent any form of sexuality from being displayed by any client living in the facility.

Completion Date: 12/21/18