STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G039	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-WASHINGTON	1307 NORTH FIFTH AVENUE WASHINGTON, IA 52353

(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 the investigation of incident #81270-I deficiencies were cited at W125 and W153.	W 000		
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 ensure staff appropriately and respectfully managed maladaptive client behavior. This affected 2 of 2 clients during the investigation of investigation #81270-I (Client #1 and Client #3) and potentially affected all clients in the home (Client #2, Client #4, Client #5, Client #6, Client #7 and Client #8). Findings follow: Record review on 2/25/19 revealed the facility Incident Investigation Overview, signed by the Quality Improvement Specialist (QIS) on 1/2/19. According to the overview, an anonymous staff at the facility made a report to the Mentor Network (a national network of health and human service providers) Hotline on 12/23/18. The staff alleged the Lead Direct Support Professional (LDSP) yelled at Client #1 in an abusive tone. The overview included employment background information including counseling provided to the LDSP on 10/18/18 for raising her voice and restricting client rights and counseling provided on 11/21/18 for raising her voice and making demands on the clients.	W 125		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G039	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-WASHINGTON	1307 NORTH FIFTH AVENUE WASHINGTON, IA 52353

(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 125	Continued From page 1 Further record review on 2/25/19 revealed the facility's Individual Rights Statement. Rights included being treated with respect and dignity and receipt of appropriate services and supports. Record review on 2/26/19 revealed an Activity Programmatic Observation Form completed by the Qualified Intellectual Disability Professional (QIDP) on 10/16/18. The QIDP noted the LDSP raised her voice when Client #3 exhibited maladaptive behavior. When interviewed on 2/25/19 at 11:00 a.m., the QIDP confirmed she witnessed the LDSP use inappropriate voice tone when clients exhibited maladaptive behaviors. When interviewed on 2/25/19 at 1:20 p.m., the Program Supervisor (PS) confirmed staff should not yell at clients as an intervention to maladaptive behavior. When interviewed on 2/25/19 at 2:12 p.m. Direct Support Professional (DSP) A confirmed she worked on 12/23/18 with the LDSP. DSP A recalled she heard the LDSP yelling at Client #1 because he pulled his ostomy bag off. When interviewed on 2/25/19 at 3:05 p.m. the LDSP confirmed she worked with Client #1 on 12/23/18. She said Client #1 "ripped" his ostomy bag off and she gave him a shower. She acknowledged being frustrated "in general" that night and admitted she raised her voice at Client #1. When interviewed on 2/26/19 at 9:31 a.m. DSP B confirmed she worked the morning shift on	W 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G039	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-WASHINGTON	1307 NORTH FIFTH AVENUE WASHINGTON, IA 52353

(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 125	Continued From page 2 12/23/18 with the LDSP. She acknowledged the LDSP sometimes yelled at clients in the home when they exhibited maladaptive behavior. She said the LDSP would yell, "Stop" and say a client name repeatedly. She confirmed the LDSP's behavior toward the clients was disrespectful. When interviewed on 2/26/19 at 1:55 p.m. DSP C confirmed she called the Mentor Network Hotline on 12/23/18 because the LDSP "yelled at the top of her lungs" at Client #1. She confirmed the LDSP discovered Client #1 pulled his ostomy bag off and began to yell at him. She said her behavior towards Client #1 lacked respect and dignity toward him. When interviewed on 2/26/19 at 12:50 p.m. the QIS confirmed she concluded the LDSP acted inappropriately toward Client #1 on 12/23/18. She confirmed the LDSP failed to follow the facility Individual Rights Statement.	W 125		
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 interviews and record review, the facility failed to ensure staff reported potential abuse according to established policies and procedures. This affected 1 of 1 client (Client #1) during the investigation of incident #81270-I.	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G039	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-WASHINGTON	1307 NORTH FIFTH AVENUE WASHINGTON, IA 52353

(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 153	Continued From page 3 Findings follow: Record review on 2/25/19 revealed the facility Incident Investigation Overview completed by the Quality Improvement Specialist on 1/2/19. The overview revealed the QIS conducted an investigation from 12/27/18 - 12/28/18 because on 12/23/18 an anonymous staff made a report to the Mentor Network (a national network of health and human service providers) Hotline of potential verbal abuse. The staff witnessed the Lead Direct Support Professional (LDSP) yelling at Client #1 in an abusive tone. The QIS noted the facility did not receive a report from the Hotline about the allegation until 12/27/18. The facility reported the incident to the Department of Inspections and Appeals (DIA) on 12/27/18. Further record review on 2/25/19 revealed the facility Abuse/Neglect Reporting, Investigation and Follow Through Policy/Procedure. According to the document, any employee who observed potential abuse should immediately make a verbal report to the person in charge or the person's designated agent. The procedure listed several staff positions as options for staff to call to report suspected abuse and directed staff if the alleged perpetrator was the person in charge to go to a higher level in the chain of command. The procedure described steps the supervisor receiving the report would take including separating the alleged perpetrator from the alleged victim. The procedure also directed staff to report the allegation of abuse to DIA within 24 hours. Record review on 2/27/19 revealed a Mentor Network report for Misconduct or Inappropriate Behavior. The document noted a call received on	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G039	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-WASHINGTON	1307 NORTH FIFTH AVENUE WASHINGTON, IA 52353

(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 153	Continued From page 4	W 153		

12/23/18 to report an allegation of verbal abuse by LDSP toward Client #1.

When interviewed on 2/25/19 at 1:20 p.m., the Program Supervisor (PS) confirmed she received a text from Direct Support Professional (DSP) C on 12/23/18 regarding the LDSP raising her voice at Client #1. She said she was not on call but responded to DSP C. She recalled the text contained no allegation of abuse so she directed DSA C to write a contact sheet (a form used to document concerns). When the PS returned to work on 12/26/18, she read the contact sheet and met with staff. She recalled she spoke with DSA C on 12/26/18 and told her she needed to report allegations according to the policy because she did not text any information about alleged abuse. She said she discussed the incident with the LDSP on 12/26/18 and the LDSP stated Client #1 ripped off his ostomy bag and she got "frustrated". The PS said she sent the information to her Program Director (PD) and on 12/27/18; she received direction from the PD to suspend the LDSP. She noted the LDSP was on call at the time of the incident, but DSP C could have called the back-up on-call person. The PS referred to the facility abuse policy/procedure and noted the directive to contact the next level of command in the chain. She acknowledged the policy directs staff to make a verbal report and said DSP C failed to follow the procedure by texting instead of making a verbal report and by not following the chain of command to make a report.

Record review on 2/26/19 revealed a Contact Sheet signed by DSA C on 12/26/18. DSA C documented the LDSP "yelled at the top of her lungs" at Client #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G039	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-WASHINGTON	1307 NORTH FIFTH AVENUE WASHINGTON, IA 52353

(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 153	Continued From page 5 When interviewed on 2/25/18 at 2:12 p.m., DSP A recalled the LDSP yelled at Client #1 on 12/23/18. She recalled discussing the incident with DSP C after the LDSP left. DSP A said DSP C called the Mentor Network hotline number. She confirmed she worked with the LDSP 12/24/18 and 12/25/18 after DSP C made the report. When interviewed on 2/25/18 at 3:05 p.m., the LDSP confirmed she worked on 12/23/18 and recalled Client #1 ripped his ostomy bag off and she gave him a shower. She recalled she left work and returned the next day and worked until 12/27/18 when the PS escorted her off the property. The LDSP confirmed she raised her voice at Client #1 on 12/23/18 due to being frustrated. When interviewed on 2/26/19 at 1:55 p.m., DSP C confirmed she sent a text to the PS on 12/23/18 to express concern about the LDSP's behavior. She further confirmed she made a call to report the LDSP for verbal abuse. She stated the LDSP yelled at the top of her lungs and asked Client #1 what was wrong with him. DSA C said she discussed the behavior with DSA A and decided to report the LDSP. She noted the LDSP was the on call and she identified the back-up on call staff. DSP C acknowledged she failed to call the back-up on call. She further acknowledged that she texted the PS but did not allege any kind of abuse in the text. DSA C could not recall what number she called or whom she spoke to when she made the call. She confirmed she worked with the LDSP on 12/24/18 - 12/26/18 following the report she made to the hotline on 12/23/18. When interviewed on 2/26/18 at 12:50 p.m., the	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G039	A. BUILDING _____ B. WING _____	C 02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-WASHINGTON	1307 NORTH FIFTH AVENUE WASHINGTON, IA 52353

(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 153	Continued From page 6	W 153		

QIS confirmed she concluded something inappropriate occurred between the LDSP and Client #1 on 12/23/18. She said during her investigation, DSA C identified herself as the anonymous staff that made a report to the Mentor Network hotline. She said the purpose of the hotline is to assist employees with issues related to their employment, or to report Medicaid fraud. She noted DSA C thought she called the Department of Inspections and Appeals (DIA) abuse reporting hotline but she called the wrong number. The QIS said the facility did not know about the allegation of abuse until 12/27/18 when her supervisor received a report from the Mentor Network. She acknowledged making a report to DIA on 12/27/18.

In summary, DSP C witnessed potential abuse and failed to follow the facility policy to verbally report suspected abuse. She failed to notify a staff person at the facility and called the Mentor Network. The failure to follow the policy resulted in a delay in separation of the victim from the alleged perpetrator and a delay in reporting the allegation to DIA.