8/8/19 OK 8/21/19

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

PRINTED: 07/22/2019
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
	16G049	A. BUILDING _____ B. WING _____	C 08/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-ASPEN 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 Investigation #82464-I completed on 4/30/19 to 6/12/19, resulted in a deficiency written at W331.	W 000	see attached	
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide clients with nursing services in accordance with their needs. This affected 1 of 1 sample client (Client #1) reviewed during investigation #82464-I. Finding follows: Record review revealed facility investigation dated 3/22/19, indicated, "On 3/22/19, upon waking (Client #1) for the morning, (Direct Support Professional (DSP) A) noticed that (Client #1's) left foot was swollen and he appeared to have weakness in his legs. Vitals were taken per (Registered Nurse (RN)) request. (DSP A and DSP B) assisted (Client #1) to the bathroom to begin his shower. (DSP A noted swelling in (Client #1's) left foot and stated that (Client #1) was not acting like himself as he continued through his morning routine with (DSP A's) assistance. While (Client #1) was sitting at the table for breakfast, (RN) attempted to obtain a second set of vitals but said that (Client #1) was combative and would not allow her to do so. (RN) determined that (Client #1) should be seen at the Emergency Room. After (Client #1) refused breakfast, (DSP A) and (DSP B) assisted him to sit in a chair in the living room. (Client #1) seemed restless while sitting in the chair, so	W 331	POC 8/22/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Stef — TITLE: Regional Director — (X6) DATE: 07/26/19

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 331	Continued From page 1 (DSP B) and (DSP A) began monitoring him more closely. At 8:20 a.m., (DSP A) and (DSP B) were beginning to assist (Client #1) into a wheelchair, however (Client #1) was unresponsive at this time. (DSP B) and (DSP A) checked for a pulse and both stated they found a faint pulse. (DSP B) and (DSP A) moved (Client #1) to the floor and asked (RN) for assistance. (RN) began CPR, (DSP A) called 911 at 8:22 a.m. (Licensed Practical Nurse (LPN)) was called for assistance. (LPN) and (RN) continued CPR until EMTs arrived. EMT's continued CPR on (Client #1), continuing to do so while going out the door to be put on the ambulance. (Client #1) was transported via ambulance to Myrtue Hospital in Harlan where he was pronounced dead shortly after his arrival." Additional record review revealed the following: a. Client #1, 42 years old, had diagnoses including: profound intellectual disability, mixed developmental disability, psychotic disorder - not otherwise specified, gastroesophageal reflux disease, constipation, history of seizure disorder. b. Nurse's notes on 3/6/19 documented monthly vitals as follows: temperature - 97.6 degrees Fahrenheit (F); pulse - 70; respirations - 16; blood pressure - 130/90; oxygen saturation - 97%. The note further documents: "Sleeping more. Continues to eat all given to him. c. Nurse's notes on 3/22/19 documented vitals taken before Client #1 got up for the day: temperature - 94.6 degrees F; oxygen saturation - 86%; pulse - 64; blood pressure - 152/90. Notes further documented left pedal edema, non-pitting with no redness or warmth. Client #1 was noted to be lethargic. The nurse documented she	W 331		

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W 331	Continued From page 2 attempted vitals again but Client #1 did not cooperate. Client grabbed for drinks but refused food. The staff assisted client to easy chair and the client continued to be lethargic. d. The facility's internal investigation documented vital signs showed in 2019, Client #1's oxygen saturation ranged 97% - 98%. When interviewed on 5/1/19 at 11:00 a.m. DSP A reported DSP B and DSP A got Client #1 out of bed on 3/22/19. She stated Client #1 had vomit on his pillow. They completed vital signs on him and his oxygen level was off, but she could not remember what the reading was. She assisted Client #1 into the shower and noticed Client #1 had a swollen foot. She reported the swollen foot to the RN. DSP A believed that is when they decided he needed to go to the Emergency Room. She assisted dressing Client #1 and got him to the table to eat breakfast. DSP A remembered Client #1 did not eat and would not hold his cup, which was unusual for him. The RN tried to complete vitals on him, but he pushed her away. DSP A and DSP B transferred Client #1 into a chair in the living room. DSP A stated Client #1 seemed uncomfortable, by moving around in the chair. DSP A left the room, for approximately three minutes, to assist another client. When she returned to the room, Client #1 was unresponsive. DSP A and DSP B yelled for the RN and transferred Client #1 to the ground. The RN started CPR and DSP A called 911. DSP A waited outside for the ambulance to arrive. In DSP A's interview in the incident investigation overview, DSP A described Client #1 to try and pick up juice during breakfast but struggled to keep a hold of it. DSP A held the cup to his mouth	W 331		

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W 331	Continued From page 3 so he could take a drink, but the juice dripped down his face. When interviewed on 5/1/19 at 10:47 p.m. DSP B reported two days prior to Client #1's death, Client #1 was congested. They had to give him cough medication and the RN monitored him for any changes. On 3/22/19, Client #1 had thick mucus on his pillow and the RN asked them to complete vital signs on Client #1 prior to assisting him out of bed. DSP B remembered Client #1's oxygen level read 86 and she immediately reported the number to the RN. The RN instructed to continue to assist Client #1 to get up for the day and she would take another set of vital signs. She assisted DSP A with Client #1 and noticed Client #1's left leg "was extremely swollen." She stated they could not get Client #1's sock or shoe on him. They assisted Client #1 to the table for breakfast, but he refused to eat. She stated Client #1 could not grip his cup. DSP B and DSP A moved Client #1 to a chair in the living room. According to DSP B, Client #1 could not get comfortable in the chair. DSP A walked away for a brief amount of time and DSP B took Client #1's plate to the kitchen. She believed she was away from Client #1 for a maximum time of five minutes. When she walked up to Client #1's chair, Client #1 was unresponsive. When interviewed on 5/1/19 at 10:30 a.m. the RN reported on the overnight facility staff administered cough medication to Client #1. On 3/22/19, she instructed facility staff to take vital signs before Client #1 got out of bed. Client #1 often refused vitals and it was easier to complete vital signs while he was still in bed. According to the RN, vital signs were normal. DSP A and DSP B got Client #1 up to shower. She stated it	W 331		

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W 331	Continued From page 4 usually took one staff to assist Client #1, but that day it took two. The RN tried to complete another set of vital signs when Client #1 sat at the kitchen table, but he pushed her away. The RN stated Client #1 drank fluids for breakfast. She did not believe he ate much, which was unusual for Client #1. The RN decided he needed seen in the Emergency Room. Facility staff transferred Client #1 into a chair in the living room while they waited for the Program Manager to arrive for an extra staff. The RN walked down the hall to administer medications to another client. Facility staff yelled for assistance because they could not get Client #1 up. At approximately 8:15 to 8:20 a.m., the RN walked back down the hallway and Client #1 was on the floor in front of the chair, not breathing. The RN started one man CPR, instructed facility staff to call 911 and the LPN at the other home. She stated Client #1 had "a lot of secretions" and when she started CPR, she knew she broke a rib. When the LPN arrived, he started compressions and she did the breaths. Additional interview on 5/29/19 at 11:24 a.m. the RN reported when vital signs are completed she did not go by oxygen level. She stated, at times, Client #1 did not leave the oxygen sensor on his finger. She also stated clients did not always take deep breaths, so the readings were not accurate. She assessed clients by their color, their actions, and the rest of the vital sign readings. The rest of Client #1's vital signs were in the normal limits. According to the RN, Client #1's leg "didn't look that swollen." She stated Client #1's sock was on when he came out to the table. The RN also stated facility staff did not report that they had trouble with his sock and shoe. When Client #1 sat at the dining table, he reached for his cup and pushed her away. When he sat at the table, the	W 331		

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W 331	Continued From page 5 RN decided a doctor should see Client #1. They asked the Program Manager to come in early so they could go to the Emergency Room, but she did not believe it was emergent. According to the RN, it was approximately 30 minutes from the time Client #1 got out of bed to CPR.	W 331		

OK 8/2/19

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

8/8/19

W 331: Facility Response:

The facility Program Supervisor, Nurse, Nursing Director and/or Program Director/QIDP, will provide individuals with nursing services in accordance with their needs. Staff will receive additional training to assist all REM personnel with identifying when an individual is in need of emergent medical care. This training may include, but is not limited to the following:

- All staff need to understand that if they believe that an individual receiving REM services is in need of emergent medical care and that contacting 911 is warranted, staff should **call 911** prior to contacting a nurse or supervisor if one is not on-site.
- Staff should know when to take a set of vital signs that may not be routine (i.e. individual reports nonspecific symptoms of physical distress such as feeling "funny" or "different", individual is acting odd, reporting pain, uncomfortable, etc.). Staff should refer to the Normal Vital Signs/Weight Chart for individuals normal vital sign ranges.
- If vital signs are abnormal or not within normal ranges for that individual they should re-take the abnormal vital(s) to ensure accuracy. If any vitals are still not within normal ranges for that individual they should notify a nurse immediately. Staff should document a new entry in the individual's nurse's notes every time vitals are taken.
- Staff/nurses should know that the Normal Vital Signs/Weight Chart for Individuals form was revised to include that, "If O2 Sat (saturation) is below 90% and the individual is displaying respiratory concerns, **call 911**." Additionally, this form will be updated with current ranges for each type of vital at least twice per year (must be done in the month of Feb. and Aug.). Previously, vital ranges were updated annually.
- Staff/nurses should know that the Normal Vital Signs/Weight Chart for Individuals form should be placed in the front holder of the med kardex for reference.
- Staff/nurses should know that the Change of Condition Decision Making Tool was revised in the EMERGENCY: CALL 911 section to include "Trouble breathing and pulse oxygen (PO2) is below 90%" and "Multiple abnormal observations" as possible scenarios of when to **call 911**.
  - Trouble breathing/abnormal respiratory observations may include: coughing, congestion, wheezing, shortness of breath, rapid breathing, shallow breathing, tracheal tugging, mouth breathing, heaving, air gulping, grunting, gurgling, vomiting, changes in skin coloring (i.e. blueness or paleness).
  - Any time trouble breathing/abnormal respiratory observations are occurring ***and*** pulse oxygen (PO2) is below 90%, **call 911**.
- The Change of Condition Decision Making Tool will be reviewed again as a guide of each employee's personal responsibility and shared accountability to ensure the wellbeing of those in REM services. This document continues to be posted for staff/nurse reference in all facilities.

To ensure a system level change, all newly hired employees receive training on the Change of Condition Decision Making Tool and the Normal Vital Signs/Weight Chart for

Individuals form is part of the on-the-job training that each new employee receives. In addition, training on both of these tools will be incorporated in to the Vitals Training that is provided to all new employees as part of the New Employee Orientation training. The Change of Condition Decision Making Tool will also be reviewed with staff at least two times per year in the months of Feb. and Aug. during staff meetings to ensure understanding and that it is in the forefront of everyone's minds. The review of this tool will also be a standing agenda item at all Nurse's Meetings for the same purpose.

To maintain and monitor ongoing compliance, nurses and program directors will review all health related incident reports and provide necessary follow-up to any employee in situations where timely medical care is not sought. In high level situations, others (i.e. Quality Improvement Specialist, Quality Improvement Manager, Area Director, Regional Director and/or Executive Director) review the situation to assist in determining appropriate actions and/or training that is needed.

Class I Violation - Fine Amount: $6250.00 - 35% Reduction Amount: $4062.50
Correction Date: 07/22/19