OK 10/21/19

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G139	A. BUILDING _____ B. WING _____	C 08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANAGER PLACE	2309 C STREET SW CEDAR RAPIDS, IA 52404

(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 The investigation of incident #84108-I, 84399-I, #84936-I, and #85063-I was conducted 8/5/19 - 8/8/19. As a result of incident #84963-I a deficiency was cited at W249. As a result of incident #84108-I, 84399-I, and #85063-I a deficiency was cited at Iowa Code 481 IAC 50.7(3).	W 000	POC 9/11/19	
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 interview and record review, the facility failed to ensure staff implemented client Individual Program Plans, specifically regarding client level of supervision, as directed. This affected 2 of 2 clients (Client #3 and Client #8) involved in the investigation of incident #84936-I. Finding follows: Record review on 8/5/19 revealed a facility Critical Incident Report (CIR), dated 6/26/19. According to the report, on 6/26/19 Client #8 reported on 6/25/19 Client #3 was in her personal	W 249		

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

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 boundaries. Client #8 reported she asked Client #3 several times to get out of her boundaries and Client #3 then touched her breasts and her "crotch" area. Client #8 again asked Client #3 to stop and Client #3 pulled down his pants far enough to expose himself. Client #8 said she asked Client #3 to stop again and then Client #8 went to her bedroom. When interviewed on 8/6/19, Youth Services Worker (YSW) A stated on 6/25/19 she was standing in the middle of the recreation room of the Sinclair Cottage. She said two clients were down walking down the hallway; Client #3 had been sitting on a rug and playing with Legos while Client #8 was on the other side of the room getting items from her locker. YSW A said she looked down the hallway to monitor the two clients and make sure there were no issues. YSW A stated Client #8 never said anything to her on 6/25/19. She said the next day, Client #8 told another staff of the incident. YSW A stated Client #3 and Client #8 did not have any special supervision requirements on 6/25/19 when the incident occurred. Additional record review on 8/7/19 revealed Team Meeting notes dated 5/1/19, 5/15/19, 5/29/19, 6/5/19, 6/12/19, 6/19/19, and 6/26/19. The notes instructed staff were to keep Client #3 within eyesight when with his peers in the cottage common areas. It noted this was due to Client #3's age and history of sexualized behaviors. The meeting notes included staff were to be present in the common area whenever other clients were in an area with Client #3 and staff were to monitor for safe and appropriate boundaries and conversations with all his peers.	W 249		

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W 249	Continued From page 2 When interviewed on 8/7/19 at 2:20 p.m., the Program Manager explained client levels of supervision were discussed during Team Meetings and were considered part of the clients Individual Program Plan. She confirmed Client #3 was to remain in staff eyesight when in common areas with peers. She explained on 6/25/19, the staff had looked out of the area to check on a peer and a pillar obstructed her view. She stated the facility planned to put up a mirror so staff would not have to turn to see down the hallway when in the recreation area. When interviewed on 8/7/19 at 3:30 p.m., Qualified Intellectual Disability Professional (QIDP) A confirmed Client #3 was to remain in staff eyesight when in common areas of the cottage with his peers. When interviewed on 8/7/19 at 5:20 p.m., Client #8 reported Client #3 had touched her breasts and "crotch" area over her clothing. She said he also pulled his pants down and exposed himself to her. Client #8 said she had asked Client #3 to leave her alone and left the area following the incident. Client #8 said staff was in the area but was not watching when it occurred. Client #8 said staff kept a close eye when Client #3 was around and she felt safe.	W 249		

DEPARTMENT OF INSPECTIONS AND APPEALS

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C 146	50.7(3) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(3) When there is an act that causes major injury to a resident or when a facility has knowledge of a pattern of acts committed by the same resident on another resident that results in any physical injury. For the purposes of this subrule, " pattern " means two or more times within a 30-day period. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the Department of Inspections and Appeals (DIA) within 24-hours after a client exhibited a pattern of peer-to-peer aggression resulting in injury more than two times in a 30-day period, as required by Iowa Code 481 IAC 50.7(3). This affected 9 of 9 clients (#1, 3, 7, 8, 9, 11, 13, 15, and 16) involved in the investigation of incident #84108-I, #84399-I, and #85063-I. Findings follow: 1. Record review on 8/5/19 revealed a facility Critical Incident Report (CIR), dated 6/21/19. The report noted Client #13 engaged in peer-to-peer aggression resulting in injury lasting 24-hours on 5/21/19, 5/24/19, and 5/31/19. The CIR documented on 5/21/19, Client #13 bit Client #11 on her left tricep and the bite mark was still visible when 24-hour follow-up was completed. On 5/24/19, Client #11 and Client #13 were standing	C 146		

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C 146	Continued From page 1 next to each other eating snack when they began kicking each other. Client #11 slapped Client #13 and Client #13 hit and grabbed Client #11's hair. During the 24-hour follow-up, Client #11 reported soreness and pain from her hair being pulled. The CIR noted the incident on 5/31/19 occurred when Client #13 slapped Client #11 on the back of the neck after Client #11 was closing the door to the family room so Client #13 could not watch the movie. Client #11 reported soreness and pain in her neck during the 24-hour follow-up. The facility reported the three incidents to the DIA on 6/21/19. 2. Record review on 8/5/19 revealed a CIR, dated 6/21/19. The report noted Client #1 had hit Client #7 on 6/10/19 with a broom resulting in a bruise on Client #7's pinky finger. On 6/11/19, Client #1 punched Client #8 in the face; Client #8 had a sore face and a bump/knot during the 24-hour follow-up. The facility failed to report the incidents to the DIA until 6/21/19. The facility completed an amended CIR on 7/8/19 (Monday) after Client #1 punched Client #7 in the face after Client #7 hit staff on 7/5/19 (Friday). Client #7 had a small bruise on the left side of his nose during the 24-hour follow-up. 3. Record review on 8/5/19 revealed a CIR, dated 7/16/19. According to the report, on 5/28/19 Client #8 hit Client #7 in the back with a scooter resulting in a bruise on Client#7's back observed during the 24-hour follow-up. On 5/31/19, Client #8 shoved Client #3 to the ground resulting in a small scratch on Client #3's knee, which remained visible during the 24-hour follow-up. The facility failed to report the two incidents to the DIA until 7/17/19. Additional record review revealed the "ICFID Peer	C 146		

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C 146	Continued From page 2 to Peer Reporting Guidelines," undated. The guidelines instructed "QIDP(s) (Qualified Intellectual Disability Professional) and Program Manager are responsible for monitoring and reporting peer to peer aggression." The guidelines instructed direct care staff were to document the peer-to-peer aggression and e-mail the report to the Program Manager, Shift Leader, and QIDP prior to the end of the shift. Direct care staff working the following shift was to complete the required 24-hour follow up for possible or sustained injuries and document in the shift change over communication. The QIDP was to input the peer-to-peer aggression on the spreadsheet and complete necessary follow-up which included ensuring 24-hour accident/injury follow-up had been completed. The guidelines defined an injury as "lasting longer than 24 hours therefore requiring a healing process." When interviewed on 8/5/19 at approximately 3:30 p.m., Qualified Intellectual Disability Professional (QIDP) A said based on how the facility defined an injury any time a client reported pain when completing the 24-hour follow-up the facility considered the client had an injury. She provided the facility peer-to-peer tracking sheet. The QIDP stated the facility would be completing another self-report on 8/5/19 due to Client #13 aggressing toward his peers and resulting in injury. She showed the Surveyor the peer-to-peer tracking sheet and stated the facility would include all four incidents in the self-report. Review of the peer-to-peer tracking sheet revealed Client #13 hit Client #11 on her back and pulled her hair on 7/5/19; Client #11 reported her head hurt during the 24-hour follow-up. The second incident occurred on 7/9/19 when Client #13 punched Client #9 in the mouth after Client	C 146		

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C 146	Continued From page 3 #9 accidentally hit Client #13's arm with a metal pole. During the 24-hour follow-up, Client #9 appeared to have a small fat lip. A third incident occurred on 7/30/19. Client #13 and Client #15 were play fighting when Client #13 pushed Client #15. Client #15 fell against the window and to the floor resulting in a red mark on his thigh. During the 24-hour follow-up, Client #15 reported the area was tender. A fourth incident occurred on 7/31/19 when Client #13 threw a stick at Client #16 and caused an abrasion on her chest; the mark was still present during the 24-hour follow-up. When interviewed on 8/7/19 at 9:55 a.m., the Program Manager (PM) explained once an Accident Injury Report (AIR) was completed it was e-mailed to right away to several people including the QIDPs. She stated 24-hour follow-up was not always communicated right away and felt this was part of the breakdown for identifying injuries from peer-to-peer aggressions. During a follow-up interview on 8/7/19 at 2:20 p.m., The PM confirmed the facility had not reported all incidents of peer-to-peer aggression resulting in injury to the DIA timely. She stated she would be completing the CIR for the incidents with Client #13 in July.	C 146		

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When interviewed on 8/5/19 at approximately 3:30 p.m., Qualified Intellectual Disability Professional (QIDP) A said based on how the facility defined an injury any time a client reported pain when completing the 24-hour follow-up the facility considered the client had an injury. She provided the facility peer-to-peer tracking sheet. The QIDP stated the facility would be completing another self-report on 8/5/19 due to Client #13 aggressing toward his peers and resulting in injury. She showed the Surveyor the peer-to-peer tracking sheet and stated the facility would include all four incidents in the self-report.

Review of the peer-to-peer tracking sheet revealed Client #13 hit Client #11 on her back and pulled her hair on 7/5/19; Client #11 reported her head hurt during the 24-hour follow-up. The second incident occurred on 7/9/19 when Client #13 punched Client #9 in the mouth after Client

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TANAGER PLACE
YOUR CHILD : OUR FOCUS

DIA Corrective Action Plan/Facility Response September 2019

C146

The ICFID leadership team (QIDPs, Program Manager, and Program Shift Leaders) will create a monthly calendar indicating who is responsible for completing timely follow up for all consumer to consumer incidents. The person responsible for completing follow up will document appropriately. QIDP's will ensure timely reporting to the department. To ensure ongoing compliance, QIDPs will check consumer to consumer tracking spreadsheet daily. In addition, a daily huddle call will occur to review previous night's incidents. A combination of QIDPs, program shift leaders, and program Manager will be present on these calls, effective 10/7/19 and ongoing at this time.

Completion Date: Immediate and ongoing

W249

Program Manager submitted a work order to get mirror installed on September 10th. Maintenance installed the mirror on September 10th. This was installed to alleviate the blind spot by the pillar from the milieu area to the recreation room in Sinclair Cottage. The presence of this mirror will allow staff the opportunity to supervise clients in the rec room and supervise other areas of the cottage.

Status: completed

Individualized supervision parameters will be reviewed weekly in team meetings to ensure ongoing compliance.

Complete date: Immediate and ongoing

Respectfully Submitted,

Michelle Allmandinger

Michelle Allmandinger
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