

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: 7028		Date: August 19, 2019			
Facility Name: REM Iowa-Terry Ave.		Survey Dates: July 22, 23, 24, 2019			
Facility Address/City/State/Zip 815 Terry Ave. Hiawatha, IA 52233					
		LK	84110-I		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date	

64.60	<p>481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.</p> <p>Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility. This rule is intended to implement Iowa Code Section 135C.2(3).</p>	II	\$500.00	Upon Receipt
W153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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.</p>			
58.43(9)	<p>481—58.43(135C) Resident abuse prohibited.</p>			

Facility Administrator

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52.2(a)	<p>58.43(9) Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III)</p> <p>481—52.2(235E) Persons who must report dependent adult abuse and the reporting procedure for those persons.</p> <p>52.2(2) Reporting suspected dependent adult abuse in facilities or programs.</p> <p>DESCRIPTION:</p> <p>Based on interviews and record review, the facility failed to ensure an allegation of abuse was immediately reported. This affected 1 of 1 client identified during the investigation of #84110-I (Client #1). Finding follows:</p> <p>Review on 7/22/19 of the facility investigation revealed Direct Support Staff (DSP) B reported she witnessed DSP A shove Client #1 on the afternoon of Saturday, 6/22/19 and possibly caused Client #1 to fall to the floor twice in the same afternoon. DSP B texted the Lead DSP on the afternoon of 6/22/19, expressing frustration with DSP A. DSP B wrote in the</p>			
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	<p>texts that she saw DSP A push Client #1 over as she sat on the floor. DSP B also texted DSP A said he put Client #1 on the floor, after DSP B heard Client #1 fall to the floor and then saw her on the ground. DSP B also noted she heard DSP A yell at Client #1 and then heard the client fall. The Lead DSP told DSP B to write up her concerns and the Lead DSP would turn them into management staff. DSP B sent the Lead DSP an email dated 6/23/19 at 10:29 p.m. with more specific information regarding the incidents. According to the email, DSP B saw DSP A shove Client #1 while she sat on the floor, which caused her to topple over onto her side. DSP B also heard Client #1 fall in the living room and as she entered the room, DSP A said, "Yeah, I put you on the floor..." A short time later, DSP A and Client #1 went to the kitchen. DSP B heard DSP A yell at Client #1 and then she heard Client #1 fall. The Lead DSP reported these allegations to the Program Director on the morning of 6/24/19. The facility began an investigation and suspended DSP A on 6/24/19.</p> <p>Record review on 7/23/19 revealed Client #1 was 54 years old with a diagnosis including Severe Intellectual Disability, Attention Deficit Disorder, Seizure Disorder, and Osteopenia.</p>			
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	<p>Client #1 was independently ambulatory, but unsteady on her feet and it was not uncommon for her to fall. She wore a helmet, knee pads and elbow pads due to frequent falls and her seizure disorder. Client #1 used some words, but did not have the ability to have a functional conversation. Client #1 had a behavior program in place with target behaviors of aggression toward self, others and objects.</p> <p>When interviewed on 7/22/19 at 2:30 p.m. , DSP B said she witnessed DSP A mistreat Client #1 on the afternoon of 6/22/19, as noted in her email dated 6/23/19. She said she texted the Lead DSP around 4:30 p.m. on 6/22/19 and told the Lead DSP of her concerns. The Lead DSP responded that she didn't really know what to do, but told DSP B to document her concerns. DSP B sent the email to the Lead DSP on 6/23/19.</p> <p>When interviewed on 7/22/19 at 4:25 p.m. the Lead DSP stated she got a text from DSP B on the afternoon of 6/22/19, expressing concerns regarding DSP A. DSP B texted that DSP A pushed Client #1 over as she sat on the floor. DSP B wrote that she heard Client #1 fall in the living room and went she went in DSP A said, "Yeah, I pushed you....." DSP B also indicated</p>			
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	<p>that DSP A had been threatening toward her. The Lead DSP was working at another agency facility at the time, and didn't know what to do. She said she told DSP B to call the on-call supervisor if things got worse. She also told DSP B to document what had happened. DSP B sent the Lead DSP an email on 6/23/19, documenting what had happened. The Lead DSP gave the email to the Program Director on 6/24/19.</p> <p>Review of DSP A's schedule and time sheet revealed he worked at the facility on Saturday, 6/22/19 from 1:55 p.m. to 7:59 p.m. DSP A was not scheduled to work on Sunday, 6/23/19. He was scheduled to work the second shift on 6/24/19, but was suspended before his shift began. The allegation made by DSP B to the Lead DSP on the afternoon of 6/22/19 was not forwarded on to a higher level of authority. DSP A continued to work with Client #1 as he finished out his shift on 6/22/19. He was not suspended until two days after the incident.</p> <p>When interviewed on 7/23/19 at 3:00 p.m. the Program Director confirmed DSP B texted her concerns to the Lead DSP on the afternoon of 6/22/19. The Lead DSP was not the on-call supervisor at the time and didn't have the</p>			
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	<p>authority to suspend DSP A. The Lead DSP should have ensured the allegation was immediately reported to the Program Director or on-call supervisor, instead of waiting until 6/24/19. The facility took corrective action with the Lead DSP regarding the incident.</p> <p>Review of the agency Abuse/Neglect Policy revealed the policy directed staff who observed or suspected abuse to immediately make a verbal report to the person in charge or the person's designated agent. The supervisor notified should direct the employee who reported the allegation to complete an Incident Report. The supervisor should immediately verbally report the allegation to the program director or designee. According to the policy, a Lead DSP was not considered to be a designee.</p> <p>FACILITY RESPONSE:</p>			
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