STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G031	A. BUILDING _____ B. WING _____	C 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-TERRY AVENUE	815 TERRY AVENUE HIAWATHA, IA 52233

(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 As the result of the investigation of #84110-I a deficiency was cited at W153.	W 000		
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 an allegation of abuse was immediately reported. This affected 1 of 1 client identified during the investigation of #84110-I (Client #1). Finding follows: 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 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	W 153	POC 8/19/19 Please see attached.	

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

Kaitlin Siddell, PROGRAM DIRECTOR 08/29/2019

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 153	Continued From page 1 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.	W 153		
	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. 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. 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. When interviewed on 7/22/19 at 4:25 p.m. the Lead DSP stated she got a text from DSP B on			

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W 153	Continued From page 2 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 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. 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. 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 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	W 153		

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W 153	Continued From page 3 DSP regarding the incident. 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.	W 153		

OK
9/10/19

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

Tag W 153: <u>Facility Response:</u>

The facility Program Directors/QIDPs or designee will ensure that all area supervisory and leadership personnel are retrained on the agency Abuse Reporting, Investigation and Follow Through procedure. This will include retraining with the following employees: facility Program Supervisors (PS), facility Lead Direct Support Professionals (LDSP), and facility QIDPs. The training will be documented accordingly via a training sheet. To maintain and monitor compliance, facility employees will continue to receive training regarding abuse reporting through discussions, at least quarterly, if not more frequently, at staff meetings. In addition, all abuse reporting training is completed in accordance with the state requirement for all staff every four years. Employees who had this training prior to 07/01/19, were grandfathered in to receiving every five years. Staff meetings are facilitated by the PS, QIDP, PD, and/or designee. Employees, regardless of their position, who have failed to report alleged abuse or neglect according to procedure will receive disciplinary action as deemed appropriate. The LDSP who failed to report to a PD or PS what had allegedly occurred to Clients #1 received formal disciplinary action in the form of a written corrective action plan.

Completion Date: 08/19/2019