STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G030	A. BUILDING _____ B. WING _____	C 11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-CRESTWOOD	3944 CRESTWOOD DRIVE N W CEDAR RAPIDS, IA 52405

(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 #87096-I deficiencies were cited at W193.	W 000	POC 2/18/20 Please see attached.	
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff competency regarding interventions to manage inappropraite client behavior and appropriate supervision of clients. This affected 1 of 1 client during the investigation of #87096-I (Client #1). Findings follow: 1. Record review on 11/12/19 revealed Client #1's Individual Incident Report (IR) dated 10/31/19. The Program Supervisor (PS) documented staff left Client #1 unsupervised from 1430 (2:30 p.m.) - 1305 (3:05 p.m.). According to the IR, Direct Support Professional (DSP) A and DSP B left the home to pick up clients at REM Developmental Services (RDS), the clients' day program. Staff failed to communicate that Client #1 remained home due to illness. Continued record review, revealed Client #1's IPP to increase his safety by reducing incidents of self-injury through anal stimulation. The IPP directed staff to check on Client #1 every 5 - 10 minutes when in his bedroom with the door closed.	W 193		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacie Siddell — TITLE: Program Director — (X6) DATE: 01/17/2020

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 193	Continued From page 1 Observation on 11/12/19 from 3:35 p.m. - 3:46 p.m. revealed Client #1 stayed in his bedroom with the door closed. Staff failed to knock on his door and check on him. When interviewed on 11/12/19 at 1:30 p.m., the Quality Improvement Specialist (QIS) confirmed she conducted an internal investigation due to the incident on 10/31/19. She said she interviewed staff and found that staff left Client #1 unsupervised from 2:35 p.m. until 3:15 p.m. (fifty minutes). She confirmed clients are to be supervised at all times. When interviewed on 11/12/19 at 2:45 p.m., DSP C confirmed she worked with Client #1 during the day on 10/31/19. She recalled he stayed in his room with the door closed due to not feeling well and running a fever. She said she checked on him every 30 - 45 minutes and offered him food and drink throughout the day. She said she last checked on him at 1:15 p.m. She recalled DSP A and DSP B arrived for their shift and the Registered Nurse (RN) told them Client #1 stayed home from RDS. She commented DSP A and DSP B did not appear to pay attention to the RN's report. DSP C defined Client #1's level of supervision as checks every 30 minutes and confirmed knowledge of his IPP to increase his safety. Upon review of the IPP, DSP C said she thought staff should check on Client #1 more often; however, the PS said to do checks every 30 minutes. When interviewed on 11/12/19 at 3:15 p.m., DSP D confirmed she worked on 10/31/19 and arrived at the home at 2:50 p.m. She could not get in the house because the door was locked and no one answered when she knocked on the door. She	W 193		

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W 193	Continued From page 2 assumed staff went to RDS to get the clients and would be back around 3:20 p.m. so she just waited outside. She recalled DSP E arrived at 3:00 p.m. and she informed him no staff were in the home. DSP D said then she received a call from DSP B who informed her Client #1 was in the home unsupervised. She said DSP E went to a lock box and entered a code to access a key to get in the home. She recalled he had difficulty getting the box to open. She went to the front of the house, looked in Client #1's window, and saw him lying in bed. She said DSP E got the key out of the lock box; they entered the home and checked on Client #1 at approximately 3:10 p.m. or 3:15 p.m. When DSP A and DSP B arrived at the home, they told DSP D no one told them Client #1 was in his bedroom. DSP D said she routinely checked on Client #1 every half hour when he spent time in his room alone. She acknowledged staff needed to check on him due to anal stimulation behavior. When shown the IPP, DSP D said she knew the program but denied knowledge of the 5 - 10 minute checks. When interviewed on 11/12/19 at 3:47 p.m., DSP E confirmed he arrived to work on 10/31/19 at approximately 3:05 p.m. and found the doors to the home locked. He knew Client #1 stayed home because he worked from 6:00 a.m. until 10:00 a.m. that day. He defined Client #1's level of supervision as half hour checks. He acknowledged the PS sent him the code to get into the house and he attempted to get in the lock box once he arrived at the home. He explained the doors automatically lock when someone exits the home and commented when no staff are in the home; no client should be in the home. He	W 193		

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recalled when he arrived, DSP D's phone rang and she told him staff left Client #1 home alone. He attempted to access the key in the lock box but had difficulty getting it open. He recalled DSP D ran to the front of the house and looked through the window to check on Client #1 and upon her return he accessed the key and they entered the home. He said he went to Client #1's bedroom and found him lying in bed asleep. He recalled DSP A and DSP B arrived five minutes later and told him they were unaware Client #1 stayed home from RDS. He confirmed no staff checked on Client #1 for at least 30 minutes on 10/31/19 because staff left for RDS at 2:35 p.m. DSP E confirmed knowledge of Client #1's anal stimulation IPP but stated he only checked on him every 30 minutes because Client #1 got upset if staff went in to check on him every 5 - 10 minutes.

When interviewed on 11/12/19 at 4:30 p.m., DSP A confirmed staff left Client #1 in the home unsupervised on 10/31/19. She said she came into work at 2:00 p.m. and denied receipt of any information that Client #1 stayed home due to illness. She said she and DSP B did not know Client #1 stayed home until they arrived at RDS to pick up clients and RDS staff told them he did not attend day program. She recalled DSP C, the RN and the PS worked in the home when she arrived but noted DSP C left shortly after she arrived. She recalled the RN told her about receipt of some support stockings for Client #2, Client #1 needing a new medicine and tasks to complete prior to the Halloween party that evening. She did not recall the RN telling her Client #1 remained home. DSP A said she and DSP B left for RDS at 2:35 p.m. She said when RDS staff told them Client #1 stayed home, DSP

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B called DSP D and alerted her to get in the home and check on him as soon as possible. She estimated they got back to the home around 3:15 p.m. and DSP D and DSP E told her they checked on Client #1. DSP A acknowledged she worked the evening shift on 10/30/19 and knew the PS gave Client #1 Tylenol for a fever but denied any discussion regarding him staying home from RDS on 10/31/19.
DSP A said Client #1 could be in his room alone but staff needed to check on him every 15 - 30 minutes. She denied knowledge of the IPP requirement to check on him every 5 - 10 minutes due to the anal stimulation behavior.

When interviewed on 11/12/19 at 4:55 p.m., DSP B confirmed she arrived at work on 10/31/19 at 2:00 p.m. with DSP A because they rode to work together. She confirmed Client #1 remained home while she and DSP A left to get the other clients at RDS. She recalled frosting donuts for the Halloween party and the RN mentioning something about a "Z Pack". DSP B said she thought it was some kind of breathing treatment and denied any information was shared regarding Client #1 being home. She said the RN and the PS left for a meeting at 2:20 p.m. and she and DSP A left at 2:35 p.m. When they arrived, RDS staff told her Client #1 stayed home. She said she called both DSP D and DSP E and told them Client #1 was inside the home alone and to go in and check on him as soon as possible. She noted staff check Client #1's bedroom prior to his arrival from RDS to see if there are any items he could use to anal stimulate or self-injure. She acknowledged she did not do the check when she came in on 10/31/19. She said she asked DSP E to do it when he came in. She identified 30-minute checks as Client #1's level of

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W 193	Continued From page 5 supervision. After reading the IPP, DSP B said the PS directed staff to check on Client #1 every 30 minutes at a staff meeting on 11/12/19. She acknowledged staff failed to maintain Client #1's level of supervision on 10/31/19 due to "miscommunication." When interviewed on 11/12/19, the Lead DSP confirmed knowledge of Client #1 being left in the home alone on 10/31/19. She said she worked that morning and recalled she stayed home with him while staff went shopping for party supplies. She noted he slept most of the time and she checked on him every 30 minutes. She confirmed staff complete bedroom checks due to potential self-injury but denied knowledge of the 5 - 10 minute checks as written in the IPP. She said the PS told staff to do 30-minute checks at a staff meeting on 11/12/19. When interviewed on 11/13/19 at 8:50 a.m., DSP F confirmed she worked with Client #1 on the morning shift. She identified his level of supervision as 30-minute checks. When interviewed on 11/13/19 at 9:10 a.m., the RN confirmed Client #1 remained at home unsupervised on 10/31/19. She said she gave report to DSP A and DSP B when they came to work, but acknowledged they did not actively listen to her report. She said they engaged in other tasks during the report and she felt she overloaded them with information. She noted she told them about Client #2's support stockings, Client #1 staying home and then asked them to complete some cooking tasks. The RN said she checked on Client #1 and left the home to attend a meeting at 2:20 p.m. She confirmed neither	W 193		

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W 193	Continued From page 6 DSP A nor DSP B saw her go in and check on Client #1. The RN said she and the PS rode to a meeting together and on the way back to the home, they saw the staff in the van behind them. She wondered if staff took Client #1 with them and called DSP B. DSP B told her Client #1 was not in the van. Upon her return to the home, the RN completed an assessment of Client #1 and noted no injuries. She estimated she completed the assessment at 3:45 p.m. The RN said staff should have taken Client #1 with them when they went to pick up the other clients. She acknowledged she did not provide that direction to DSP A or DSP B. She acknowledged Client #1 remained at home unsupervised for approximately 55 minutes on 10/31/19. The RN said she checked on Client #1 every 10 - 15 minutes due to his anal stimulation IPP and noted he had a history of self-injury. She stated 5-minute checks would cause Client #1 to become agitated. When interviewed on 11/13/19 at 10:00 a.m., the PS confirmed staff left Client #1 alone in his bedroom on 10/31/19. She said the RN gave shift report to DSP A and DSP B prior to leaving with her to attend a meeting. She recalled the RN reported Client #1 stayed home and she needed to pick up a Z Pack for him. She noted the RN also gave the DSPs directives regarding cooking things for the party. The PS said after the meeting, she and the RN were driving and saw the van behind them. When the RN called and asked if Client #1 was with them DSP B said no because no one told them he was home. She said she knew DSP D and DSP E were coming in at 3:00 p.m. and she had texted DSP E the code to unlock the lock box to get in the home because she knew no one would be home. She	W 193		

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W 193	Continued From page 7 commented she assumed staff would take Client #1 with them when they left the home to pick clients up at RDS. She denied giving staff that directive. The PS said staff should check on Client #1 every 5 - 10 minutes when he was in his room alone due to anal stimulation behavior. She admitted she told staff to check on him every 30 minutes at the staff meeting because the Supervision and Support procedure noted checks at 30-minute intervals. She said the procedure and the IPP contradicted each other. The PS noted the IPP should be updated because Client #1 got irritated if staff checked on him more than once every 15 minutes. She commented the Qualified Intellectual Disability Professional (QIDP) who wrote the IPP no longer worked at the facility. The PS confirmed staff failed to maintain Client #1's level of supervision per his IPP and further failed to provide supervision per the facility procedure. She also noted staff failed to complete the bedroom check prior to leaving for RDS and questioned if completion of the check would have resulted in the DSPs realization that Client #1 remained home. She acknowledged nothing in the IPP directed staff to complete the check prior to leaving for RDS. When interviewed on 11/13/19 at 11:50 a.m., the RDS Program Supervisor confirmed she heard RDS staff tell DSP A and DSP B that Client #1 remained home on 10/31/19. She recalled the DSPs seemed surprised. When interviewed on 11/13/19 at 12:15 p.m., the Program Director confirmed staff failed to follow Client #1's IPP and the facility Supervision and Support Procedure. She acknowledged staff failed to maintain Client #1's designated level of	W 193		

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W 193	Continued From page 8 supervision to ensure his safety. Further record review revealed the facility Supervision and Support Procedure. The procedure identified the staff requirement to provide the level of support and supervision needed to ensure clients received continuous active treatment. The procedure directed staff to engage and provide supervision to clients at a minimum of every 30 minutes, unless the clients' individual program plan (IPP) specifically outlined the frequency of supervision. 2. Record review on 11/12/19 revealed Client #1's IPP to increase his safety by reducing self-injurious anal stimulation. Approved restrictions included daily bedroom and bathroom "sweeps". Staff should go through Client #1's dresser drawers, all containers, the garbage, etc. to ensure no access to items to use for anal stimulation. Record review on 11/13/19 revealed Client #1's October 2019 Daily Room Sweeps restriction record. The record lacked documentation of sweeps completed on October 8th, 9th, 10th, 15th, 16th, 17th, 24th and 31st. When interviewed on 11/12/19 at 3:51 p.m., DSP E confirmed staff do bedroom sweeps when Client #1 was not present to remove items he could use to complete anal stimulation. When interviewed on 11/12/19 at 4:55 p.m., DSP B confirmed staff should complete daily bedroom sweeps to ensure Client #1's safety. She stated she did not complete a sweep on 10/31/19 and asked DSP E to complete the sweep because	W 193		

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W 193	Continued From page 9 she kept busy preparing for a Halloween party. When interviewed on 11/12/19 at 5:15 p.m., the Lead DSP confirmed staff should complete bedroom sweeps at 2:00 p.m. before Client #1 returned from day program. When interviewed on 11/13/19 at 9:10 a.m., the Registered Nurse (RN) said staff should complete a bedroom sweep in Client #1's bedroom when they come to work at 2:00 p.m. She confirmed DSP A or DSP B should have completed a bedroom sweep on 10/31/19. When interviewed on 11/13/19 at 10:00 a.m., the Program Supervisor (PS) confirmed Client #1's IPP directed staff should complete a sweep of Client #1's bedroom every day prior to his return from the day program. When interviewed on 11/13/19 at 12:15 p.m., the Program Director (PD) confirmed staff failed to document completion of bedroom sweeps on multiple days in October 2019.	W 193		

✓ 2/3/20 OK 11/9/2020

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

Tag W 193: Facility Response: Client #1's Individual Program Plan addressing self-injurious anal stimulation was revised on 12/05/19 to better reflect the client's needs. Staff were retrained on the revised program as evidenced by the correlating Individual Program Plan Training Sheet. Systematically, the facility QIDP, Program Supervisor (PS), and/or Program Director/QIDP (PD) or designee will ensure that training on all clients' Individual Program Plans routinely takes place as needed (e.g. when plans are implemented, revised, or as needed based on any other factor). This training will occur at staff meetings or informally with staff during their shifts as needed. To maintain and monitor ongoing compliance, in addition to routine review and training on Individual Program Plans, the facility QIDP, PS, Lead DSP or designee will complete reviews of staff documentation on Individual Program Plan data sheets to ensure staff are implementing programs correctly. Specifically related to this incident and client #1, the facility QIDP, PS, Lead DSP, or designee will closely monitor documentation of daily room sweeps being completed.

Additionally, related to this incident and systematically, a new form was implemented on the day of the incident titled "Verification of Individuals Present" which requires staff at each shift change to communicate who is present at the facility and who is absent for any reason (such as at day program, gone on a home visit, etc.). Staff then sign the form to indicate that they discussed this information with each other. Staff were trained on this expectation and training was documented via a training sheet. All staff were retrained on the agency expectations regarding support and supervision beginning on 11/06/19. Staff signed a training sheet to indicate that they had reviewed and understand the REM Iowa ICF Supervision and Support Procedure.

Completion Date: 02/08/2020