

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

Citation Number: 9012					Date: December 11, 2020
Facility Name: REM Iowa 36th Avenue					Survey Dates: August 31, 2020 – September 14, 2020
Facility Address/City/State/Zip 29 36th Ave. SW Cedar Rapids, IA 52404					
		LK	90277-I, 90796-C, 90982-I, 91190-C		
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.</p> <p>This rule is intended to implement Iowa Code Section 135C.2(3).</p>	II	\$500.00	Upon Receipt
64.33	<p>481—64.33(135C) Allegations of dependent adult abuse. 64.33(1) 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>			
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>			

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52.2	<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 style="margin-left: 20px;">a. If a staff member or employee is required to make a report pursuant to this rule, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the Department within 24 hours of such notification or the next business day.</p>			
235E.2	<p>Iowa Code section 235E.2(3)(a)</p> <p>3. a. If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within twenty-four hours.</p> <p>DESCRIPTION:</p> <p>Based on interviews and record review, the facility staff failed to immediately report all allegations of client mistreatment and/or abuse to a supervisor, or designee, in accordance with facility policy.</p>			

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	<p>This affected 1 of 2 clients (Client #3) involved in the investigations of #90277-I, #90796-C, #90982-I, and #91109-C. Findings follow:</p> <p>1. Record review on 8/31/2020 revealed a facility internal investigation, initiated 3/23/2020. According to the investigation, on 3/23/2020 Direct Support Professional (DSP) A called Program Supervisor (PS) A and reported on 3/22/2020 she witnessed DSP B smack Client #3 across the face. PS A immediately reported the allegation to the Program Director (PD). DSP A and PS A spoke again and DSP A reported she also had witnessed DSP B and DSP C both pull Client #3's hair on 3/22/2020.</p> <p>Continued record review revealed Client #3 was a 35-year-old female who resided at the facility since 5/18/2011. Client #1 had diagnoses including severe intellectual disability, anxiety disorder not otherwise specified, self-injurious behaviors, impulse control disorder, bipolar 2 disorder, and enuresis. Client #3 had an Individual Program Plan (IPP) in place to increase socially acceptable behavior by reducing self-injurious behaviors. Target behaviors addressed by the IPP included hitting herself and hitting her head or hands on hard surfaces. The IPP instructed if Client #3 started to exhibit possible antecedents or signal behaviors, staff were to implement de-escalation techniques as identified within the IPP. If this was unsuccessful, staff were to offer Client #3 a break in her bedroom, walk to</p>			
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	<p>with Client #3 to her bedroom and then check on Client #3 every three to five minutes. If Client #3 choose not to take a break and continued to escalate, the IPP instructed staff to establish a physical presence, while not speaking to Client #3, as a cue for her to de-escalate. Staff were to provide Client #3 an indirect verbal prompt, such as offering to go swing, if her behavior continued. If the indirect verbal prompt was unsuccessful, staff were to provide a direct verbal prompt to stop the behavior. If Client #3 continued to engage in self-injurious behaviors, the IPP instructed staff to block by using their body and could implement the use of blocking pads. If blocking was unsuccessful, the IPP instructed staff to utilize a two-person physical restraint until Client #3 displayed observable signs of relaxing but for no longer than 30-minutes. Additional restrictive measures used in conjunction with the IPP included behavior modifying medications (Haldol, Depakote, and Ativan).</p> <p>Additionally, Client #3 had an IPP in place to reduce acts of aggression toward others and/or objects. The IPP identified target behaviors of hitting, tipping furniture, pulling hair, and throwing objects. The IPP instructed staff to attempt de-escalation techniques when Client #3 began to exhibit antecedents and/or signal behaviors. Staff were to offer Client #3 a break in her bedroom if she continued to escalate; walking with her to her bedroom and checking on her periodically to ensure her safety. If Client #3 refused to take a</p>			
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	<p>break, staff were to provide an indirect prompt to assist with calming. If Client #3 continued, staff were to provide a direct verbal prompt and then block the aggression. The IPP instructed staff to implement a two-person physical restraint, until Client #3 began to calm but not to exceed 30-minutes, if Client #3's behaviors escalated and blocking was unsuccessful. Additional restrictive measures utilized in conjunction with the IPP included the use of behavior modifying medications (Haldol, Depakote, and Ativan).</p> <p>When interviewed on 9/2/2020 at 9:50 a.m., PS A reported she received a phone call from DSP A on 3/23/2020. She said DSP A reported on 3/22/2020 Client #3 was on the floor having a behavior when DSP B and DSP C kept pushing Client #3 back down to the floor. PS A explained she did not recall exactly if DSP A reported DSP B or DSP C had pulled Client #3's hair and DSP B had also smacked Client #3 on the face. PS A confirmed DSP A failed to report the allegation immediately and had waited until the following day, 3/23/2020, to report. PS A stated she asked DSP A why she had not reported the allegation immediately and DSP A stated she did not report immediately because the staff and supervisors at the facility were all friends. PS A stated she immediately called and reported the allegation to the Program Director.</p> <p>When interviewed on 9/2/2020 at 3:50 p.m., DSP A reported Client #3 had followed DSP C out of</p>			
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	<p>the kitchen to the living room and began to have a behavior. Client #3 was yelling and banging her head. DSP A said Client #3 was by the dining room and door to the front foyer when DSP A checked on her and Client #3 briefly stopped the behavior but started again after DSP A returned to the living room. DSP A stated she retrieved the blocking pads and was blocking Client #3 from hitting her head. DSP A stated DSP B and DSP C came from the living room as Client #3 was crawling toward her and DSP B stated Client #3 was going to try to bite her; DSP A said she told Client #3 "no". DSP A reported DSP B grabbed Client #3 by the back of her hair, pulled Client #3 down, and kind of slammed Client #3 to the floor onto her back. DSP A stated Client #3 continued her behavior when DSP C grabbed Client #3 by the back of the hair, pulled her down, and kind of slammed Client #3 onto her back on the floor. DSP A stated approximately five to six seconds later she, DSP B, and DSP C physically restrained Client #3. DSP A reported Client #3 started to calm and stated she wanted to go to her bedroom so they released the physical restraint. DSP A said Client #3 started to crawl toward DSP B, smacked DSP B on the leg, and in response DSP B forcefully smacked Client #3 across her face on the cheek area. DSP A was unable to recall if there was a mark or redness on Client #3's face but recalled Client #3 began to cry even louder. DSP A stated Client #3 continued her behavior for a brief time before she calmed. DSP A reported later in the evening,</p>			
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	<p>Client #3 followed DSP B around telling DSP B she was sorry. DSP A stated she did not report the allegation immediately because everyone at the facility was close, including the staff and supervisors, therefore she called PS A the following day (3/23/2020) to report the allegation.</p> <p>2. Record review on 8/31/2020 revealed a facility internal investigation, initiated 4/25/2020. According to the internal investigation, on 4/25/2020, Lead Direct Support Professional (LDSP) A called Program Supervisor (PS) B and reported DSP D had drug Client #1 by his ankles to his bedroom after Client #1 had aggressed toward Client #3. DSP D was immediately sent home and an internal investigation was initiated. On 4/27/2020, the facility interviewed DSP D. At this time, DSP D reported earlier in the morning on 4/25/2020 Client #3 was in her bedroom having a behavior and DSP E was with her. DSP D stated he went to check on them and observed Client #3 was sitting on the floor, DSP E was standing bent over in front of Client #3; Client #3 hit DSP E and DSP E responded by hitting Client #3 with an open hand on the left shoulder. The facility reported the allegation to the Iowa Department of Inspections and Appeals.</p> <p>When interviewed on 9/1/2020 at 12:00 p.m., Program Supervisor (PS)B reported on Lead Direct Support Professional (LDSP) A called her and reported DSP D had drug Client #1 by his</p>			
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	<p>ankles to his bedroom during a behavioral incident. PS B stated she went into the facility, called DSP D into her office, and sent him home due to the allegation. PS B explained DSP D did not report to her he had witnessed DSP E hit Client #3 on her shoulder area during a behavioral incident earlier in the shift on 4/25/2020. PS B stated, from her understanding, DSP D reported the allegation a couple of days later when he was interviewed during the internal investigation for the allegation between him and Client #1.</p> <p>When interviewed on 9/2/2020 at 4:20 p.m., LDSP A reported on 4/25/2020 she was called into the facility by DSP E because Client #3 was having behaviors and DSP D was not helping. LDSP A stated she arrived to the facility and things seemed okay other than Client #3 was having a behavior. She stated she and DSP E were assisting with Client #3 when Client #1 approached and grabbed Client #3's hair. She stated she and DSP E were attempting to untangle Client #1's hands from Client #3's hair when DSP D approached them. She stated after they were able to get Client #1's hands out of Client #3's hair, DSP D grabbed Client #1 by the ankles and drug him across the hall to his bedroom door. She stated she immediately called and reported the incident to PS B. LDSP A stated DSP D did not report to her DSP E had hit Client #3 earlier in the shift, prior to her arriving to the facility.</p>			
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	<p>When interviewed on 9/3/2020 at 2:45 p.m., DSP D reported on 4/25/2020 at approximately 8:00 a.m. Client #3 came out of her bedroom and DSP E sent Client #3 back to her bedroom. He stated Client #3 had been throwing clothes so he went to see if DSP E needed any assistance. DSP D stated Client #3 was on the floor and DSP E was standing over her attempting to get Client #3 to put her clothes away. DSP D stated Client #3 reached up and hit DSP E on the chest area with an open hand. DSP D reported DSP E responded by hitting Client #3 on the shoulder area with an open hand. DSP D said after Client #3 had hit DSP E, DSP E said something along the lines of she was not dealing with this. DSP D confirmed he did not immediately report the allegation because there was no one present to report to. He explained PS B arrived at the facility and told him about the allegation against him; he was shocked and just left. DSP D stated he thought about the incident all day so called the Iowa Department of Inspections and Appeals on 4/26/2020 to report the incident. DSP D confirmed he did not report the incident to the facility until 4/27/2020 when he was interviewed for the internal investigation regarding the incident between Client #1 and himself.</p> <p>Review of facility policies revealed the "Abuse/Neglect Reporting, Investigation and Follow Through" policy, last revised 9/25/2017. The policy instructed any employee who observed</p>			
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	<p>or suspected abuse, neglect, or potentially abuse acts were to immediately make a verbal report to the person in charge or the person's designated agent. The policy identified the person in charge or designated agent included the program's supervisor, on-call supervisor, another supervisor, a quality improvement specialist, QIDP, program director, regional director or the state quality improvement manager. The policy continued to instruct the supervisor was to immediately report the allegation verbally to the program director, or designee.</p> <p style="text-align: center; margin-top: 20px;">FACILITY RESPONSE:</p>			
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