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

PRINTED 12/11/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G033	A. BUILDING _____ B. WING _____	C 09/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-36TH AVENUE	29 36TH AVENUE S W 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 onsite Infection Control Survey, the annual health facilities survey, and the investigation of #90277-I, #90796-C, #90982-I, and #91109-C were conducted 8/31/2020 -9/3/2020, and 9/14/2020. As a result of the onsite Infection Control Survey, no deficiencies were cited. As a result of the annual health facilities survey, no deficiencies were cited. As a result of the investigations of #90277-I, #90796-C, #90982-I, and #91109-C, a deficiency was cited at W153.	W 000	please see attached POC 12/11/20	
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 staff failed to immediately report all allegations of client mistreatment and/or abuse to a supervisor, or designee, in accordance with facility policy. This affected 1 of 2 clients (Client #3) involved in the investigations of #90277-I, #90796-C, #90982-I, and #91109-C. Findings follow: 1. Record review on 8/31/2020 revealed a facility	W 153		

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

Dibura | Program Director | 12/11/20

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 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. 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 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	W 153		

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W 153	Continued From page 2	W 153		

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).

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 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).

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

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W 153	Continued From page 3 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. When interviewed on 9/2/2020 at 3:50 p.m., DSP A reported Client #3 had followed DSP C out of 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	W 153		

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W 153	Continued From page 4 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, 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. 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.	W 153		

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W 153	Continued From page 5 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 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. 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.	W 153		

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W 153	Continued From page 6 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. 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 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	W 153		

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W 153	Continued From page 7 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.	W 153		

OK

Accept this plan as the facilities credible allegation of compliance.

Tag W 153: **Facility Response:** The facility Program Director/QIDP, facility Program Supervisor and/or facility QIDP will ensure that all allegations of mistreatment, neglect or abuse are reported immediately to the administrator or their designee in accordance with State law and per company procedure. Employees will be retrained and reminded of reporting expectations, including who to report to and to ensure that they are reporting to the appropriate agency. To ensure on-going compliance, all employees of REM Iowa will review the Abuse Reporting Procedure quarterly at facility staff meetings.

Class I Violation – Fine Amount: $500.00 (35% reduction = $325.00)
Completion Date: 12/11/2020