STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G044	A. BUILDING _____ B. WING _____	C 11/16/2020

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REM IOWA-CORALVILLE	1985 HOLIDAY ROAD CORALVILLE, IA 52241

(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 A recertification survey was conducted on 11/2/20 - 11/16/20. Deficiencies were cited at W192, W249, and W268. The investigation of #94117-I resulted in a determination of Immediate Jeopardy (IJ). On 11/4/20 at 2:40 p.m., Immediate Jeopardy was determined based on the facility's failure to ensure staff competency to keep clients safe. The facility was notified on 11/4/20 at 3:40 p.m. The facility developed a plan to remove the IJ, which included installation of alarms and staff training. The IJ was removed on 11/12/20 at 3:10 p.m. The facility was found to be out of compliance with the Condition of Participation Facility Staffing. Deficiencies were cited at W158 and W193 as a result. During the investigation of #89505-C, no deficiencies were cited.	W 000	See attached POC 2/22/21	
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to comply with the Condition of Participation (COP): Facility Staffing. The facility failed to provide adequate training to ensure staff competently and consistently demonstrated skills and supervision supports to ensure client safety. Cross reference W193 Based on interview and record review facility staff failed to demonstrate	W 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Program Director

(X6) DATE: 01/23/2021

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 158	Continued From page 1 the skills needed to manage client behavior and ensure client safety. On 11/4/20 at 2:40 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure staff competency to keep clients safe. The facility was notified on 11/4/20 at 3:40 p.m. The facility developed a plan to remove the IJ, which included increased staff involvement to silence alarms and re-training of staff on client Individual Program Plans (IPPs). The IJ was removed on 11/12/20 at 3:10 p.m.	W 158		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed toappropriately administere medications according to physician's orders and facility policy. This affected 2 of 3 sample clients observed during medication administration (Client #2 and Client #3). Findings follow: 1. Observation on 11/3/20 at 3:40 p.m. revealed Certified Medication Aide (CMA) A administered medications in full tablet form to Client #2. Record review on 11/5/20 revealed Client #2's Dietary Assessment and Order (DAO) signed by his physician on 9/15/20. The order noted staff should crush Client #2's medications.	W 192		

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W 192	Continued From page 2 Further record review revealed the facility Preparation of Medication for Administration Policy/Procedure. The document directed medications "shall be prepared precisely according to physician's orders." When interviewed on 11/5/20 at 11:15 a.m., the Program Supervisor (PS) confirmed she administered medications. She stated she gave Client#2 his medications whole and did not crush them. When re-interviewed on 11/5/20 at 11:45 a.m., the PS confirmed Client #2's Physician Order changed on 9/15/20. She stated she did not know the order changed but confirmed staff should crush his medications prior to administering them. 2. Observation on 11/4/20 at 7:06 a.m. revealed CMA B prepared Client #3's medications. She initialed the Medication Administration Record (MAR) prior to presenting the medications for administration to Client #3. When interviewed on 11/4/20 at 7:15 a.m., CMA B confirmed she documented administration of Client #3's medications before he took them. She said she understood she could chart after checking the medications three times. When asked what she would do if Client #3 spit the medications out, she said she would report it to the nurse. Record review on 11/5/20 revealed the facility Administration of Medications Policy/Procedure. According to the policy/procedure, CMAs should	W 192		

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W 192	Continued From page 3 chart administration of medication only after the medication had been administered. When interviewed on 11/5/20 at 8:05 a.m., the Nursing Director confirmed staff should initial administration of medication after the client received them.	W 192		
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 observations, interviews and record review, the facility failed to ensure staff competency to implement programs to keep clients safe. This affected 1 of 1 client during the investigation of #94117-I (Client #1). Findings follow: Record review on 11/2/20 revealed the following: a. An Incident Investigation Overview completed by the Quality Improvement Specialist (QIS). The investigation summary revealed a police officer arrived at the facility on 10/25/20 at approximately 10:40 a.m. He asked if any clients were missing and gave a physical description of Client #1. Certified Medication Aide (CMA) A checked the home and discovered Client #1 missing. The Lead Direct Support Professional (LDSP) followed the officer around the block, identified Client #1 and brought him back to the facility. b. Client #1's Individual Program Plan (IPP) to	W 193		

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W 193	Continued From page 4 reduce acts of elopement (leaving the facility without staff knowledge)directed staff assigned to Client #1 to test each facility exit door and Client #1's Wander Guard band at the beginning and end of each shift. Staff interventions included checking on him every five minutes while awake to ensure his presence in the home. The IPP directed staff to prompt Client #1 to utilize his iPad/picture cards any time he wanted to exit the facility. c. Client #1's IPP to reduce acts of PICA (ingestion of non-edibles) identified Client #1's level of supervision as five minute checks (during waking hours) and 30 minute checks on the overnight shift or if he chose to go to his room for personal time. According to the IPP, staff should perform environmental sweeps (scan the area for items Client #1 could ingest) when he entered a room or went to his bedroom. d. The facility Individual Diagnosis list indicated Client #1's diagnoses included severe intellectual disability, autism, PICA, Mixed Receptive-Expressive language disorder, incontinence and hyperopia (farsightedness). e. The facility Supervision and Support Procedure required staff to provide the level of support and supervision needed to ensure clients received an active program of interventions and services to achieve the objectives in the IPP. The procedure prohibited staff from leaving a client unsupervised. f. Client #1's Comprehensive Functional Assessment (CFA) completed on 5/25/20 identified street safety as a need for Client #1. Staff documented he needed "full assistance"	W 193		

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W 193	Continued From page 5 with street safety including understanding "Stranger Danger", understanding traffic lights, understanding traffic signs and knowing how to cross the street safely. The Maladaptive Behavior section of the CFA noted Client #1 had programs in place for PICA, elopement, stealing and aggression behaviors. Observations at the facility on 11/2/20 at 3:40 p.m. revealed a wooden gate in the front entrance of the home, and a vinyl gate on the west side of the home near the back patio area. The fences included multiple latches to secure the gates. Observation at the facility on 11/2/20 at 3:45 p.m. revealed a Wander Guard panel on the front door although no alarm sounded when Client #1 walked past the entry door. Client #1 wore a Wander Guard band on his right ankle. Observations revealed a picture of the yard and the word "outside" posted on the entrance door, the door to the patio and the back exit door near Client #1's bedroom. A Wander Guard alarm panel existed on all three-exit doors. The exit door near Client #1's bedroom door also had a Detex alarm. When interviewed Certified Medication Aide (CMA) A confirmed the Wander Guard alarm should sound when/if Client #1 exited the building. He noted the Detex alarm was loud and would sound when anyone opened the door and exited the facility. He mentioned he worked on 10/25/20 and did not hear an alarm sound prior to discovery of Client #1's absence. Observation at the home on 11/2/20 at 4:05 p.m. revealed a vinyl fence and gate approximately 15	W 193		

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W 193	Continued From page 6 feet from the exit door nearest Client #1's bedroom on the east side of the home. CMA A stated he found the gate open when he checked it after learning Client #1 eloped on 10/25/20. He recalled he helped Client #6 in the shower and only found out Client #1 eloped when a police officer knocked on the door and asked if anyone was missing. He said he looked through the house and realized Client #1 left the home without supervision. CMA A noted he had never seen Client #1 open the gate but had seen him "mess with it." He again denied hearing any alarm go off on the day Client #1 eloped. When interviewed on 11/2/20 at 4:10 p.m., CMA A confirmed the LDSP held responsibility for Client #1 at the time of the incident. When interviewed on 11/2/20 at 5:25 p.m., the Qualified Intellectual Disability Professional (QIDP) confirmed staff should check on Client #1 every five minutes. She acknowledged since the incident on 10/25/20 staff should "keep an eye on him" but did not define what she meant. She noted the facility did not provide one to one staff for any clients. On 11/2/20 at approximately 5:50 p.m., an alarm sounded from the back of the house. When interviewed at 6:10 p.m., the Program Supervisor (PS) stated the Wander Guard sounded because she had to reset it as it flashed red, indicating it was not functioning properly. She explained staff check the alarms on the doors each day on each shift. Observation at 6:15 p.m. revealed the Wander Guard alarm on the back door (by Client #1's bedroom) flashed red. The PS came to the door	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 193	Continued From page 7 and stated the light should be green. She left and returned with a remote device and reset the alarm. She explained if the Wander Guard flashed red, the alarm would sound when anyone went out the door. She noted the system should only go off when someone wearing a band exited the door. She said she had no idea how Client #1 eloped from the facility without staff being aware. She added, Direct Support Professional (DSP) A should have checked the alarm when she came on shift at 6:00 a.m. on 10/25/20. When interviewed on 11/2/20 at 6:20 p.m., the PS stated DSP C told her the Wander Guard alarm worked when he checked it on 10/25/20. She noted he told her he checked the alarm "manually" but she did not know what he meant. She said staff should use the remote to check the alarm. Record review on 11/3/20 revealed Client #1's IPP Data Sheet for October. The data sheet identified each door in the facility and the Wander Guard band for each shift during the month. The document directed staff to test all three door alarms and the Wander Guard band. In addition, the data sheet directed staff to notify a supervisor immediately if an alarm did not sound so staff could increase supervision of Client #1. Staff failed to check the alarms on first shift as evidenced by a lack of documentation on the data sheet. Record review on 11/3/20 revealed Client #1's Individual Incident Report (IR) dated 10/25/20. The IR completed by CMA A described events leading up to the discovery that Client #1 left the home without staff knowledge. The writer noted once asked by an officer if anyone was missing,	W 193		

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W 193	Continued From page 8	W 193		

staff conducted a search of the house and realized Client #1 left the facility unsupervised. According to the IR, LDSP followed the officer out the door, got in the van and returned with Client #1. CMA A completed a full body check and obtained a set of vitals. The IR indicated Client #1 sustained a small abrasion on the top of his left and right big toes.

When interviewed on 11/3/20 at 2:25 p.m., the Program Director (PD) confirmed no documentation of any injuries existed for Client #1 since 5/19/20. She noted staff investigated the abrasions on his toes as injuries of unknown origin because no staff documented their existence prior to his elopement on 10/25/20.

When interviewed on 11/3/20 at 8:05 a.m., the LDSP confirmed he came into work on 10/25/20 due to DSP C going home ill. He confirmed he worked with CMA A and DSP A. He reviewed the staff schedule and confirmed his assigned clients included Client #1. He recalled he last saw Client #1 at approximately 10:15 a.m. sitting on the couch in the living room holding some sensory items. He defined Client #1's level of supervision as "eyes on him." The LDSP said he left the living room to go to the kitchen to make a call to the PS and to begin making lunch. He said he verbally told CMA A and DSP A he was going to the kitchen. The LDSP estimated between 10:40 a.m. - 10:45 a.m., CMA A knocked on the kitchen door, said there was an officer at the door, and asked about Client #1's whereabouts. He went to the door and acknowledged Client #1 matched the description given by the officer of an individual found a block away. He recalled CMA A went down the hall to Client #1's room, returned, and informed the officer Client #1 was not in the

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W 193	Continued From page 9 building. The LDSP said the officer asked him to get in his vehicle and follow him. He said he drove around the block from west to north to east and upon reaching the east side of the block; he spotted Client #1 walking with two officers. The Lead DSP confirmed Client #1 wore only a T-shirt and shorts, no shoes or socks. He estimated the temperature was around 40 degrees. The LDSP acknowledged he did not test the alarms when he arrived at 8:00 a.m. because he assumed staff completed them at 6:00 a.m. when they arrived on shift. The LDSP acknowledged he did not follow Client #1's level of supervision and provide five minute checks and he was unaware if DSP A or CMA A provided them once he entered the kitchen. He suggested the other staff may have assumed Client #1 went to his bedroom for private time, but confirmed staff should have conducted a sweep of the room if he had gone to his bedroom. The LDSP confirmed he saw scrapes on both of Client #1's big toes. The LDSP confirmed the Detex alarm on the back exit door nearest Client #1's bedroom was loud and should be on at all times. He said he did not hear the alarm sound on 10/25/20. He noted staff have to get a key to disarm the alarm once it goes off. He could not explain how Client #1 exited the building without staff awareness but he did confirm Client #1's inability to safely cross the street. Observation at the home on 11/3/20 at 9:20 a.m. revealed the surveyor could hear the Detex alarm in the kitchen when the PS exited the back door. The PS confirmed staff have to use a key to turn the alarm off and on. When interviewed on 11/3/20 at 10:30 a.m., the State Climatologist identified the temperature in	W 193		

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W 193	Continued From page 10 Coralville on 10/25/20 between 10:00 a.m. - 11:00 a.m. as 38 degrees. He noted a north/northeast wind created a wind chill of 31 degrees. When interviewed on 11/3/20 at 10:45 a.m., the Quality Improvement Specialist confirmed she conducted the investigation overview. She acknowledged her interviews with staff on duty on 10/25/20 revealed no staff checked the alarms per Client #1's IPP. She stated staff failed to follow the level of supervision established in his IPPs. She noted DSP A thought Client #1 went to his room but she failed to check and ensure his location. She confirmed staff interviews revealed no staff on duty heard the alarms on the back door sound on 10/25/20. She verified the Detex alarm on the back door sounded loud when activated, and concluded the alarm must have been turned off. When interviewed on 11/3/20 at 12:00 p.m., the PS confirmed she received a call on 10/25/20 regarding Client #1's elopement. She stated she interviewed staff by phone and confirmed the LDSP held responsibility for him at the time of the incident. . She noted staff are to communicate exchange of supervision of Client #1 if/when they cannot provide his required level of supervision. She recalled DSP C told her when he heard the alarm sound he checked it manually. He told the PS he had never been trained on how to reset the alarm with a remote. She also noted in the past, she found the alarm on the front patio door turned off even though staff are trained not to turn the alarm off. Since the incident, the PS indicated she retrained staff on Client #1's IPP and how to test the alarms. The PS confirmed Client #1 could unlatch the gate in the front of the house but she had never seen him leave through the	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 193	Continued From page 11	W 193		

other gates. The PS commented staff "dropped the ball" when they failed to provide appropriate supervision and follow Client #1's IPPs. She confirmed Client #1 could not cross the street safely.

On 11/3/20 at approximately 8:25 a.m., the LDSP said staff should give Client #1 a snack or a sensory item to redirect him from the door to teach him not to elope. He failed to note the use of an iPad or picture cards to communicate a desire to leave the facility.

When interviewed on 11/3/20 at 1:05 p.m. DSP D confirmed he worked the overnight shift on 10/24/20 - 10/25/20 and checked the alarms when he arrived at 10 p.m. on 10/24/20. He said he checked the alarm on all three doors but did not check the Wander Guard band on Client #1's ankle. He said he may turn the alarm off to let staff in during shift change but then turns the alarm back on. He did not see DSP A or DSP C check the door alarms when they arrived on shift at 6:00 a.m. on 10/25/20.

When interviewed on 11/3/20 at 2:00 p.m., DSP C stated he worked from 6:00 a.m. - 7:30 a.m. on 10/25/20. He recalled DSP A came in at 6:00 a.m. and CMA A arrived at 7:00 a.m. He called the PS to ask to go home due to not feeling well and left at 7:30 a.m. He contended he knew nothing about the incident regarding Client #1's elopement until he received a call from the Quality Improvement Specialist. He acknowledged the front door alarm worked because he recalled it went off when he arrived at work the night before. He said he heard the patio door beep when DSP D took the garbage out. He said he did not check the back exit door near

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W 193	Continued From page 12 Client #1's bedroom that morning. DSP C could not recall if the light on the Wander Guard alarms were red or green. He stated he did not receive training on how to use the remote to check the Wander Guard alarm until after Client #1's elopement incident on 10/25/20. When interviewed on 11/3/20 at 2:35 p.m., DSP A confirmed she worked at the home on 10/25/20. She said she observed Client #1 walk down the hall at approximately 10:20 a.m., but did not see him enter his bedroom. She did not know who held responsibility for him at the time. She recalled CMA A helped Client #6 in the shower and the LDSP went to the kitchen to prepare lunch. She said she sat in the dining room and played a table game with two clients and remembered Client #1 sat on the couch in the living room. She did not go check on Client #1 and she did not hear any alarms sound. She confirmed she did not check the alarms on the doors when she started her shift. She stated they realized later in the day that the Wander Guard alarm on the back exit door and the Wander Guard band were not working correctly. She acknowledged no staff checked the band prior to the elopement. She recalled Client #1 was dressed in a T-shirt and shorts but no socks and shoes prior to the elopement. She defined his level of supervision as ten-minute checks but stated she did not know for sure. DSP A confirmed Client #1 could not safely cross the street. She recalled CMA A completed an assessment upon his return and recalled he had scratches on both big toes. DSP A said staff were unaware Client #1 left the home unsupervised until an officer came to the door and asked if any clients were missing.	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G044	A. BUILDING _____ B. WING _____	C 11/16/2020

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REM IOWA-CORALVILLE	1985 HOLIDAY ROAD CORALVILLE, IA 52241

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W 193	Continued From page 13 When re-interviewed on 11/3/20 at 4:10 p.m., CMA A confirmed no alarm sounded when Client #1 eloped on 10/25/20. Observation on 11/3/20 at 4:20 revealed the PS opened the front entrance door as Client #1 walked by and the Wander Guard alarm failed to sound. The PS reset the alarm with the remote. She prompted Client #1 to go out the patio entrance door and the Wander Guard alarm sounded. The PS failed to prompt Client #1 to touch the picture on the door or use an iPad to request to go outside. The PS and Client #1 came back inside and the PS reset the alarm on the patio door. Staff prompted Client #1 to get his coat to go on a van ride. When Client #1 approached the door to leave, staff failed to offer him an iPad or prompt him to touch the picture on the door to indicate his desire to leave the facility. When interviewed on 11/4/20 at 11:25 a.m., the Coralville Police Sergeant confirmed a call came in to the department on 10/25/20 and officers were dispatched to a home north of the facility at 10:35 a.m. The Sergeant noted the Reporting Person (RP) observed an individual enter and exit her vehicle, come up the stairs to her home and hit himself in the head. She reported the individual wore a "tracking device". The Sergeant said the RP reported the individual went into another vehicle two houses to the east of her home. He confirmed Client #1 would have had to cross the street to get from the facility to the addresses given by the RP. On 11/4/20, the surveyor drove around the block from the facility to the address of the RP's home. Observation revealed Client #1 would have had to cross the street to gain access to the RP's	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 193	Continued From page 14	W 193		

vehicle. The facility failed to ensure Client #1's safety while crossing the street on 10/25/20.

When interviewed on 11/6/20 at 2:30 p.m., Officer A confirmed he went to the facility on 10/25/20 and asked a male staff (later identified as CMA A) if any clients were missing. He stated initially staff denied any elopement by Client #1, so he urged staff to check the home. He recalled a few minutes later staff acknowledged Client #1's absence and the LDSP followed him around the block. He said they drove from the west to the north and then saw two officers walking with Client #1 on the east side of the facility. Officer A confirmed Client #1 wore a T-shirt and shorts but no shoes or socks. He described the weather as "cold."

When interviewed on 11/6/20 at 2:45 p.m., Officer B stated he responded to a call on 10/25/20 and was the first officer to arrive on the scene (the RP's address). He saw Client #1 standing in the driveway of the RP's home. He recalled the RP reported Client #1 went through two vehicles, hit himself and came up the steps to her home. Officer B said Client #1 was yelling and hitting himself in the head when he saw him. He described Client #1 as dressed "inappropriately" in a T-shirt, shorts and no shoes or socks. He acknowledged he wore a coat because the weather was "cold". He confirmed Client #1 was unsupervised.

When interviewed on 11/6/20 at 3:00 p.m., Officer C recalled he and Officer D went to the RP's address due to a report of a young man going through cars and banging on the homeowners door. He believed Client #1 got into the vehicle to get warm because the weather was cold and he

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	16G044	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-CORALVILLE	1985 HOLIDAY ROAD CORALVILLE, IA 52241

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W 193	Continued From page 15 had no socks or shoes on and wore a T-shirt and shorts. He confirmed Client #1 crossed the street in order to get from the facility to the address of the RP. When interviewed on 11/6/20 at 3:15 p.m., Officer D stated she arrived second on scene of the incident. She said the weather was cold so she and Officer C asked Client #1 to get in their vehicle. She recalled Client #1 started to get in the car but then got out and walked down the street. She said Officer C prompted Client #1 to walk in the grass since he was barefoot and it was cold outside. She confirmed they crossed the street with him to walk back towards the facility. Officer D recalled Client #1 wore a T-shirt and shorts. She noted he was shaking, possibly due to the cold. When interviewed on 11/9/20 at 5:00 p.m., the Program Director (PD) confirmed repair personnel found a problem with the Wander Guard system on 11/6/20. When interviewed on 11/12/20 at 1:20 p.m., the PS confirmed she conducted more training with staff to ensure Client #1's safety. These findings resulted in a determination of Immediate Jeopardy on 11/4/20 at 2:40 p.m., based on the facility's failure to ensure staff competency to keep clients safe. The facility was notified on 11/4/20 at 3:40 p.m. The facility developed a plan to remove the IJ, which included increased staff involvement to silence alarms and re-training of staff on client Individual Program Plans (IPPs).	W 193		

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	16G044	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 193	Continued From page 16 The IJ was removed on 11/12/20 at 3:10 p.m.	W 193		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure staff consistently and correctly implemented Individual Program Plans (IPPs). This affected 2 of 3 sample clients (Client #1 and Client #2). Findings follow: 1. Observation on 11/2/20 during the evening meal revealed Certified Medication Aide (CMA) B repeatedly held Client #1's wrist to prevent him from taking a bite of his food. Record review on 11/2/20 revealed Client #1's IPP to increase dining skills by eating at an appropriate pace and using utensils. The IPP directed staff to assist him to use his iPad to activate a phrase to slow down and/or to use his fork/spoon. The IPP indicated staff could use blocking to prevent Client #1 from putting more food in his mouth and possibly choking. The IPP lacked any directive to hold Client #1's wrist to prevent rapid pace or eating with his fingers.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 17 When interviewed on 11/5/20 at 1:30 p.m., the Qualified Intellectual Disability Professional (QIDP) demonstrated blocking as placing a hand over his plate of food. She confirmed staff should not hold Client #1's wrist to slow him down. 2. Observation on 11/2/20 during the evening meal revealed the Program Supervisor (PS) prompted Client #2 to count to ten prior to taking a drink of his supplement. The PS switched out with Direct Support Professional (DSP) B who prompted Client #2 to tap his leg and count to ten prior to taking another drink. Observations on 11/3/20 from 7:30 a.m. - 7:45 a.m. revealed staff prompted Client #2 to count to ten prior to taking another drink of his liquids. Observations on 11/4/20 from 7:45 a.m. - 8:35 a.m. revealed Client #2 counted to ten with staff prior to drinking his supplements. Observations during lunch on 11/4/20 revealed Client #2 counted to ten between bites when prompted by staff. At 12:35 p.m., he counted to five and took a drink. DSP B told him he needed to count to ten before taking another drink. Observations on 11/5/20 at 2:40 p.m. revealed Client #2 sat at a table and drank water. He tapped his leg and counted to ten between drinks. When interviewed on 11/5/20 at 2:50 p.m., the PS stated staff should prompt Client #2 to count to ten between drinks because counting to five did not allow enough time for him to swallow appropriately.	W 249		

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	16G044	A. BUILDING _____ B. WING _____	C 11/16/2020

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W 249	Continued From page 18 Record review on 11/2/20 revealed Client #2's IPP to increase self-feeding skills by eating and drinking at an appropriate pace. The program directed staff to encourage Client #2 to tap his leg for five seconds in between drinks. When interviewed on 11/5/20 at 1:25 p.m., the QIDP confirmed the IPP directed staff to prompt Client #2 to count to five. She acknowledged she heard staff ask him to count to ten on 11/2/20. She noted staff inconsistency could create confusion for Client #2.	W 249		
W 268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure staff engaged clients in activities to promote growth and development. This affected 3 of 3 sample clients (Client #1, Client #2 and Client #3). Findings follow: 1. Observations throughout the survey revealed staff failed to engage Client #3 in functional tasks as evidenced by the following: 11/2/20 from 3:45 p.m. - 4:20 p.m., Client #3 spun a ball on a table with no interactions from staff. At 4:25 p.m., CMA A initiated a game with Client #3 and Client #7. 11/3/20 7:45 a.m. Client #3 sat on the couch in	W 268		

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	16G044	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-CORALVILLE	1985 HOLIDAY ROAD CORALVILLE, IA 52241

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W 268	Continued From page 19 the living room, then stood up and walked to the dining room. Direct Support Professional (DSP) E asked him if he wanted a sensory item and handed him a ball. Client #3 sat down at the table, then stood up and threw the ball down the hall. DSP B directed him to "take a seat." Client #3 put the ball in the closet, walked down the hall and went to his bedroom. He remained in his bedroom and at 9:00 a.m., DSP E reported he had fallen asleep. Observations at 3:23 p.m. revealed Client #3 sat at a table with a ball until approximately 4:10 p.m. when he went to the medication room. From 4:15 p.m. until 4:25 p.m., he sat at the table and spun a tambourine. No staff offered him any other activity or task. 11/4/20 Client #3 sat at a table and spun a ball from approximately 7:25 a.m. - 7:35 a.m. The Program Supervisor (PS) sat at the table with him but offered no other meaningful activity. 2. Observations during lunch on 11/4/20 revealed no napkins on the table or offered to Client #1, Client #2 and Client #3. Staff failed to encourage the clients to use a napkin to wipe their face/hands during the meal. Record review on 11/2/20 revealed the facility policy regarding employee interactions with individuals receiving services. According to the policy, staff should promote each client's growth, development and independence through positive interactions and training methods. When interviewed on 11/10/20 at 2:35 p.m., the Program Director (PD) confirmed staff should include clients in meaningful activities to increase	W 268		

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W 268	Continued From page 20 their independence.	W 268		

dk 1/28/21

Accept this plan as the facilities credible allegation of compliance.

Tag W 158: **Facility Response:** The facility Program Supervisor and/or Lead DSP met with each staff member to ensure each staff member fully understood what their expectations were to ensure client safety as it pertains to supervision supports. Each staff member signed off on a training sheet indicating that they were aware of what is required of them in regards to client #1's supervision and safety. Client #1's elopement program was revised and keyed locks were added to all in/out doors of the facility as well as to Client #1's bedroom door and the Informed Consent was updated accordingly. Signs were posted on facility gates to remind staff to ensure the gates are fully closed and latched and staff will verify this as well at the beginning and end of each shift and document accordingly. Staff were re-trained on Client #1's PICA program. Stanley Health Care who is contracted to repair/fix the WanderGuard system has been working on installing a 15 Second Delayed Egress Door System and this should be in place and fully functional by 01/25/2021. Systematically to maintain and monitor compliance, the facility Program Supervisor, Lead DSP, QIDP and/or Program Director/QIDP will complete at least two observations a month to ensure all individual's programs are being implemented as written and that documentation is being completed. During observations, on-the-spot feedback/coaching will be done if programs are not being implemented and/or documentation is not being completed properly. These observations will continue at this frequency until the facility deems that they are meeting expectations consistently.

Tag W 192: **Facility Response:** Re-training by a facility nurse and/or Nursing Director will be conducted with staff regarding individual's Dietary Assessment Orders (DAO's) and adhering to them as written. In addition, Certified Medication Aides (CMAs) will be re-trained on the Medication Administration Procedure, with emphasis on when to complete documentation during a medication pass. These re-trainings will be documented accordingly. Systematically to maintain and monitor compliance, the facility Program Supervisor, Lead DSP, QIDP and/or Program Director/QIDP will complete at least two medication administration observations a month to ensure all individual's programs and medication administration expectations are being implemented as written and that documentation is being completed following the administration of the medications. During observations, on-the-spot feedback/coaching will be done if programs and/or medication expectations are not being implemented and/or documentation is not being completed properly. These observations will continue at this frequency until the facility deems that they are meeting expectations consistently.

Completion Date: 01/13/2021

Tag W 193: **Facility Response:** See facility response to Tag W 158

Tag W 249: **Facility Response:** The facility QIDP will provide re-training on Client #1 and Client #2's eating programs and this re-training will be documented accordingly. Systematically to maintain and monitor compliance, the facility Program Supervisor, Lead DSP, QIDP and/or Program Director/QIDP will complete at least two meal time observations a month to ensure all individual's meal time programs are being implemented as written and that documentation is being completed. During observations, on-the-spot feedback/coaching will be done if programs are not being implemented. These observations will continue at this frequency until the facility deems that they are meeting expectations consistently.

Tag W 268: **Facility Response:** The facility QIDP, Program Director and/or designee will complete an Active Habilitation Refresher training with the staff at the program, which will be

documented accordingly. Systematically to maintain and monitor compliance, the facility Program Supervisor, Lead DSP, QIDP and/or Program Director/QIDP will complete at least two activity/programmatic observations a month to ensure all individuals are being offered activities and/or encouraged to participate in a variety of tasks/activities. Observations that occur during meal times, should ensure that staff are offering the individuals napkins and that they are being encouraged to wipe their faces as needed. During observations, on-the-spot feedback/coaching will be done if activities and/or active habilitation is not being completed. These observations will continue at this frequency until the facility deems that they are meeting expectations consistently.

Completion Date: 02/22/2021

OK 1/28/21

Accept this plan as the facilities credible allegation of compliance.

Tag W 158: **Facility Response:** The facility Program Supervisor and/or Lead DSP met with each staff member to ensure each staff member fully understood what their expectations were to ensure client safety as it pertains to supervision supports. Each staff member signed off on a training sheet indicating that they were aware of what is required of them in regards to client #1's supervision and safety. Client #1's elopement program was revised and keyed locks were added to all in/out doors of the facility as well as to Client #1's bedroom door and the Informed Consent was updated accordingly. Signs were posted on facility gates to remind staff to ensure the gates are fully closed and latched and staff will verify this as well at the beginning and end of each shift and document accordingly. Staff were re-trained on Client #1's PICA program. Stanley Health Care who is contracted to repair/fix the WanderGuard system has been working on installing a 15 Second Delayed Egress Door System and this should be in place and fully functional by 01/25/2021. Systematically to maintain and monitor compliance, the facility Program Supervisor, Lead DSP, QIDP and/or Program Director/QIDP will complete at least two observations a month to ensure all individual's programs are being implemented as written and that documentation is being completed. During observations, on-the-spot feedback/coaching will be done if programs are not being implemented and/or documentation is not being completed properly. These observations will continue at this frequency until the facility deems that they are meeting expectations consistently.

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Completion Date: 01/13/2021