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

PRINTED: 10/19/2021
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
	16G039	A. BUILDING _____ B. WING _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-WASHINGTON	1307 NORTH FIFTH AVENUE WASHINGTON, IA 52353

(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 following actions and findings were competed from 9/13/21 - 9/23/21: Investigation #96893-I resulted in a deficiency cited at W153. Investigation #95989-I resulted in deficiencies cited at W191 and W289. Investigations #99603-I and #97399-I resulted in a deficiency cited at 50.7 (3) The focused infection control survey resulted in a deficiency cited at W455.	W 000	POC 11/28/21	
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 staff immediately reported incidents of potential abuse. This affected 1 of 1 client during the investigation of #96893-I (Client #4). Findings follow: Record review on 9/13/21 revealed Client #4's Individual Incident Report (IR), dated 3/19/21. Direct Support Professional (DSP) A documented DSP B pulled Client #4's hair and called her names. On 3/24/21, the Program Supervisor (PS) noted initiation of an internal investigation.	W 153	~~x~~please see attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anne Sagrusell, Area Director — TITLE — (X6) DATE: 10/29/2021

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 153	Continued From page 1 When interviewed on 9/14/21 at 12:10 p.m., DSP A confirmed she wrote the IR dated 3/19/21, and intended to tell the PS about the incident that night. She recalled DSP B stayed and talked to the PS so she decided to call and talk with the PS later. DSP A noted she had a few days off and then spoke to the PS on 3/23/21 about DSP B calling Client #4 names. She spoke with the PS again on 3/24/21 and told the PS about DSP B allegedly pulling Client #4's hair. DSP A confirmed she received Dependent Adult Abuse training and understood staff needed to report potential abuse within 24 hours of the incident. She acknowledged a delay in her reporting of the incident. When interviewed on 9/14/21 at 1:15 p.m., the PS confirmed DSP A made a report of potential abuse to Client #4 on 3/24/21. She recalled she came in to work the overnight shift on 3/19/21 and both DSP A and DSP B remained on duty. She recalled she spoke with DSP B and DSP A left without speaking to her. The PS said DSP A came to see her on 3/23/21 and voiced concerns about DSP B's verbal interactions with Client #4. She denied receiving any information regarding potential physical abuse. She recalled DSP A approached her again on 3/24/21 and made an allegation that DSP B pulled Client #4's hair on 3/19/21. Record review on 9/14/21 revealed the facility's Abuse/Neglect Reporting, Investigation and Follow Through Policy/Procedure. The document contained the following directive to staff, "Any employee who observes or suspects abuse, neglect, or potentially abusive acts directed toward an adult in a licensed REM facility will immediately make a verbal report to the person in	W 153		

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W 153	Continued From page 2 charge or the person's supervisor." When interviewed on 9/21/21 at 12:55 the Program Director (PD) confirmed staff should immediately report suspected incidents of abuse to a supervisor.	W 153		
W 191	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' behavioral needs. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure staff followed client supervision levels to ensure client safety. This affected 1 of 1 client during the investigation of #95989-C (Client #5). Findings follow: Observations on 9/13/21 at 4:10 p.m. revealed the Registered Nurse (RN) accompanied Client #5 outside and checked the latch on the gate. She returned to the house and completed other duties. Client #5 remained in the backyard and the Lead Direct Support Professional (DSP) looked out to check on him at 4:30 p.m. The Lead DSP again checked on Client #5 at 4:45 p.m. and 5:00 p.m. At 5:20 p.m., the RN walked outside, prompted Client #5, and he came into the house with her. Staff failed to check on Client #5 every five minutes while he spent time out in the yard. Record review on 9/21/21 revealed Client #5's Individual Program Plan (IPP) to reduce acts of elopement. According to the IPP, Client #5 could be in the fenced in gated back yard without staff presence with five minute checks completed by	W 191		

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W 191	Continued From page 3 staff. When interviewed on 9/21/21 at 12:35 p.m. the Qualified Intellectual Disability Professional (QIDP) confirmed staff should check on Client #5 every five minutes to ensure his safety due to his elopement behavior.	W 191		
W 285	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to incorporate behavior interventions into client individual program plans (IPPs). This affected 2 of 2 clients during the investigation of #95989-C (Client #5 and Client #6). Findings follow: Observation on 9/13/21 at 4:00 p.m. revealed the Program Supervisor left the kitchen door open and went down the hall to assist Client #1. The Registered Nurse (RN) closed the door and advised the PS not to leave the door open with no staff in the kitchen. At the time, Client #5 sat in a chair in the medication room and Client #6 sat on a chair in the living room. At 5:25 p.m. the PS left the kitchen, closed the door and the surveyor noted the door automatically locked. At 5:55 p.m. Client #6 stood in the kitchen while the PS prompted her to serve herself food items for the evening meal. Client #6 reached across	W 285		

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W 285	Continued From page 4	W 285		

the counter into a bowl and ate a piece of a canned peach. She then reached over and grabbed a slice of tomato off the counter and ate it. Staff directed her to the dining room.

At 6:10 p.m. Client #5 stood in the kitchen, reached over the counter, took food off a serving plate and ate it. The PS directed him out to the dining room.

Observation on 9/14/21 at 7:40 a.m. revealed DSP C and Client #5 walked out of the kitchen. DSP D remained in the kitchen with Client #8. Client #5 walked back into the kitchen and took cereal off of a plate on the counter. DSP C directed him out of the kitchen.
Observation at 8:05 a.m. revealed the kitchen door closed and locked while clients ate in the dining room with DSP C and DSP D assisting as needed. At 8:15 a.m. DSP D unlocked the kitchen door and several clients took their dishes to the sink. At 8:20 a.m. the door was closed and locked.

Record review on 9/20/21 revealed Client #6's IPP to reduce acts of food stealing. The IPP noted Client #6 stole or attempted to steal food/drinks and staff directives included redirecting her to another task, signing "no more," offering a free food and directing her to the dining room if Client #6 stole food. The IPP lacked any information regarding locking the kitchen door.

Record review on 9/21/21 revealed Client #5's IPP to reduce food stealing behavior. Interventions in the IPP included directing Client #5 out of the area, offering him a sensory item and redirecting him to another task. The IPP failed to identify locking the kitchen door as an

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W 285	Continued From page 5 intervention. When interviewed on 9/21/21 at 3:45 p.m. the Qualified Intellectual Disability Professional (QIDP) confirmed the kitchen door should be closed and locked when no staff could be in the kitchen with clients for client safety. She acknowledged Client #5 and Client #6's food stealing behaviors and noted she failed to include the locked door as a behavioral intervention in their IPPs.	W 285		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to encourage clients to wash their hands to promote infection control. This affected 8 of 8 clients in the home (Client #1, Client #2 Client #3, Client #4, Client #5, Client #6, Client #7 and Client #8). Findings follow: 1. Observation on 9/13/21 at 4:20 p.m. revealed Client #6 took a spoon out of a drawer in the kitchen and ate peaches out of a bowl in the kitchen. Staff failed to prompt or encourage her to wash/sanitize her hands prior to eating. Client #1 picked up a bowl of peaches from the kitchen counter, took a spoon out of a drawer in the kitchen and walked to the dining room. She sat at the table and ate without being prompted to wash or sanitize her hands. 2. Observation on 9/14/21 at 7:50 a.m. revealed Client #3, Client #5 and Client #7 sat at tables in	W 455		

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W 455	Continued From page 6	W 455		

the dining room. Client #5 rubbed his hand over his hair on his head. Staff prompted clients to get their plates and eat. Client #1 and Client #6 came to the dining room, sat down and ate their morning meal. At 8:05 a.m. Client #8 walked to the dining room sat down at a table and ate breakfast. At 8:10 a.m. Direct Support Professional (DSP) D pushed Client #2 in his wheelchair to the dining room and assisted him to eat. When asked if any of the clients washed their hands prior to eating, DSP C she did not know. She stated she administered medications most of the morning and did not assist with client hand washing.

When interviewed at 8:25 a.m. while he fed Client #2, DSP D stated he did not prompt any clients to wash hands prior to eating breakfast on 9/14/21.

At 8:35 a.m., Client #4 pedaled herself to the dining room table. She then pedaled to the doorway of the kitchen. DSP C offered her a thermal cup and Client #4 drank from the cup. Staff failed to encourage her to wash/sanitize her hands prior to drinking.

Record review on 9/13/21 revealed the facility Infection Control-Individual Receiving Supports Policy/Procedure. The policy/procedure directed all DSPs to consistently encourage and teach individuals to wash their hands. The document identified good hand washing as the "single most effective means of preventing the spread of infection."

Further record review on 9/14/21 revealed the Pandemic Influenza Preparedness and Response Plan Policy/Procedure. The facility guidance included promotion of healthy hygiene habits in

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W 455	Continued From page 7 client homes including hand washing. When interviewed on 9/14/21 at 2:05 p.m. the Program Supervisor (PS) confirmed staff should follow the facility policies and encourage clients to wash their hands throughout the day.	W 455		

DEPARTMENT OF INSPECTIONS AND APPEALS

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	IAG0102	A. BUILDING: _____ B. WING _____	C 09/23/2021

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N 103	50.7(3) 481- 50.7 (10A,135C) Additional notification. 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(3) When there is an act that causes major injury to a resident or when a facility has knowledge of a pattern of acts committed by the same resident on another resident that results in any physical injury. For the purposes of this subrule, " pattern " means two or more times within a 30-day period. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to report patterns of peer to peer aggression to the department as required. This affected 1 client added to the sample (Client #1) during the investigation of #97399-I and 99603-I. Findings follow: Record review on 9/13/21 revealed Client #1's Individual Incident Report (IR) dated 5/19/21. The report indicated Client #6 grabbed Client #1's arm and left three scratches on the bicep of her right arm. Further record review revealed another IR dated 6/2/21. Direct Support Professional (DSP) A noted Client #6 became agitated and aggressed at Client #1. The Registered Nurse (RN) documented existence of scratch marks and some purple bruising on both of Client #1's arms on 6/3/21.	N 103	*please see attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], Area Director — TITLE — (X6) DATE: 10/29/2021

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 103	Continued From page 1 Record review on 9/14/21 revealed the facility Injuries, Incidents and Incident Reporting Policy and Procedure. The document directed staff to complete an Incident Report anytime a peer to peer aggression resulted in an injury and report the injury to a supervisor. According to the policy, the supervisor would report the injury to the Program Director (PD) to determine if the Department of Inspections and Appeals (DIA) report should be completed. The policy defined a pattern of acts of peer to peer aggression as two or more times in 30 days. When interviewed on 9/14/21 at 1:25 p.m., the Program Director (PD) confirmed the facility failed to report the two incidents of peer to peer aggression to the department. She said the incident on 5/19/21 occurred at the day program and their tracking system did not include incidents at the day program. She acknowledged the error in their tracking system resulted in their failure to report the incidents.	N 103		

ok

Accept this plan as the facilities credible allegation of compliance.

Tag W153: 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 were retrained and reminded of reporting expectations, including who to report to and to ensure that they are reporting immediately. To ensure on-going compliance, all employees of REM Iowa will review the Abuse Reporting Procedure quarterly at facility staff meetings.
Completion Date: 11/28/2021

Tag W191: Facility Response: The facility Program Supervisor, facility QIDP, Lead DSP, facility Program Director and/or Designee will ensure that individuals programs are implemented as written. Re-training will be completed for Client #5's elopement program and the supervisor expectations for Client #5 will be reviewed per the program. Re-training on this program will be documented accordingly. Systematically, the facility Program Supervisor, Lead DSP, QIDP, Program Director/QIDP and/or designee will compete at least two observations per month to ensure that all individual's programs are being implemented as written and that staff are ensuring health and safety checks for an individual who elopes. During observations on-the-spot feedback/coaching will be done if programs are not being completely properly and supervision expectations are not being followed as the program indicates.
Completion Date: 11/28/20/21

Tag W285: Facility Response: The facility Program Supervisor, facility QIDP, Program Director/QIDP and/or Designee will ensure consent for the environmental modification of locking the facility kitchen is gained and put in place via an Informed Consent for Client #5 & Client #6, as well as updating the facility's environmental modification letters to reflect a locked kitchen for peers in the home. Client #5 & Client #6's programs for PICA will be updated to reflect this new restriction and re-training on these programs will be completed and documented accordingly. Re-training about shutting the kitchen door when staff are not in the kitchen to provide supervision will be done and documented accordingly. When the facility Program Supervisor, facility QIDP, facility Program Director/QIDP and/or designee are completing programmatic observations (see Tag W191), they will ensure that the kitchen door is shut (if necessary) and will provide on-the-spot coaching/feedback if applicable.
Completion Date: 11/28/2021

Tag W455: Facility Response: The facility Program Supervisor, facility QIDP, facility Program Director/QIDP and/or Designee will ensure that staff understand the importance of hand washing for themselves as well as the individuals in services. Staff will be re-trained on the Pandemic Influenza Preparedness & Response Plan Policy and the Infection Control – Individuals Receiving Supports Policy and training will be documented accordingly. When the facility Program Supervisor, facility QIDP, facility Program Director/QIDP and/or designee are completing programmatic observations (see Tag W191), they will ensure that they are observing to make sure individuals are washing their hands as needed throughout the observation period and will provide on-the-spot coaching/feedback if applicable.
Completion Date: 11/28/2021

ok

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

Tag N 103: <u>Facility Response:</u>

The facility Program Coordinator/QIDP, facility Program Director/QIDP and/or designee will ensure all patterns of acts committed by the same resident on another resident that result in any physical injury will be reported within 24 hours or the next business day to the Department of Inspections and Appeals and are not late. This occasion was an accidental oversight due to the incident occurring at an outside agency's day program and the information not being passed along timely to be added to the tracking sheet record. Both of these instances were reported to the Department on 10/11/2021 via the online reporting system. Re-training will be done on the Injuries, Incidents and Incident Reporting Policy, with specific focus on reporting peer-to-peer aggressions and this re-training will be documented accordingly. Program Directors continue to use a tracking sheet to record incidents of peer to peer injuries to ensure that patterns of aggressions causing injury are reported to the department timely. Any time an individual causes an injury to a peer; this tracking sheet will be cross-referenced to verify if this incident would meet the standard to be considered a pattern and thus meet the reporting requirement.

Completion Date: 10/19/2021