

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

Citation Number: 9086		Date: April 16, 2021		
Facility Name: One Vision Pebblestone		Survey Dates: March 15, 2021 – March 22, 2021		
Facility Address/City/State/Zip 755/765 Pebblestone Lane Garner, IA 50438		LK	#95160-I	
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> <p>DESCRIPTION:</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional</p> <p>Based on interviews and record review, the facility failed to ensure the Qualified Intellectual Disability Professional (QIDP) monitored and coordinated supports and services as determined</p>	I	\$10,000.00	Upon Receipt
W159				

Facility Administrator

Date

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	<p>by the Interdisciplinary Team (IDT). This affected 1 of 1 client during the investigation of # 95160-I (Client #1) and 2 of 10 clients currently residing at the facility (Client #2 and Client #6) Findings follow:</p> <p>1. Record review on 3/15/21 revealed Client #1's GER involving a choking incident on 12/1/20. Further record review revealed Client #1's Individual Support Plan (ISP) completed on 9/26/20. According to the ISP, the IDT agreed staff should cut Client #1's food into bite size pieces and supervise him while he consumed food.</p> <p>Record review on 3/17/21 revealed a hospital report form. The report indicated medical staff removed a 4 x 3 cm.(centimeter) piece of chicken from Client #1's throat following the choking incident. (Based on a Google search, four centimeters equaled 1.57 inches and three cm. equaled 1.18 inches).</p> <p>Further record review revealed a Nutritional Assessment completed by the facility's Registered Dietician (RD) on 8/24/20 . The assessment indicated Client #1 ate a regular, soft, high fiber diet, with food cut "bite size". The RD defined bite size as 1-inch pieces.</p>			
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	<p>Record review on 3/16/21 revealed two information sheets previously placed in a binder regarding Client #1's diet. The sheets included provision of ½ inch sized pieces rather than one inch pieces. The information sheets lacked any mention of Client #1's IDT decision to provide supervision when he ate.</p> <p>When interviewed on 3/17/21 at 10:10 a.m., the QDDP confirmed she wrote one of the information sheets and confirmed she included cutting his food into ½-inch pieces for staff reference. She acknowledged she failed to include supervision on the document. The QDDP stated she included an information sheet created by Client #1's previous provider and noted the sheet identified his food should be cut into ½-inch bite size pieces.</p> <p>Record review of a Nutritional Assessment completed by the facility's Registered Dietician (RD) on 8/24/20 revealed Client #1 ate a regular, soft, high fiber diet, with food cut "bite size". The RD defined bite size as one-inch pieces.</p> <p>When interviewed on 3/17/21 at 10:15 a.m., the QDDP confirmed the inconsistencies in the size of bite and the lack of supervision information regarding Client #1's diet.</p>			
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	<p>2. Observation on 3/16/21 at 4:50 p.m. revealed a dietary information sheet on the refrigerator at House 755 for staff reference. The sheet lacked any information regarding Client #6's diet.</p> <p>When interviewed on 3/16/21 at 4:55 p.m., the QDDP confirmed she failed to update the document when Client #6 moved into the house in December.</p> <p>3. Record review on 3/17/21 revealed a binder with information for each client's diet. No guidance regarding Client #2's and Client #6's diets could be located in the binder.</p> <p>When interviewed at 9:45 a.m. on 3/17/21, the QDDP said diet information for all clients should be located in the binder. She acknowledged the lack of information regarding Client #2 and #6.</p> <p>When interviewed on 3/17/21 at 10:20 a.m., the QDDP stated staff should follow the information in the binder to ensure clients received the proper diet to ensure their safety.</p>			
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W192	<p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, interviews and record review, the facility failed to ensure competent implementation of Individual Support Plans. This failure affected 2 of 2 client during the investigation of #95160-I (Client #1 and Client #2) and potentially affected all clients in the facility (Client #3, Client #4, Client #5, Client #7, Client #8, Client #9, Client #10 and Client #11). Findings follow:</p> <p>1. Record review on 3/15/21 revealed Client #1's General Event Record (GER) dated 12/1/20. The GER recorded a choking incident resulting in Client #1 becoming nonresponsive and staff implementation of Cardio Pulmonary Resuscitation (CPR). Staff called 911; paramedics arrived and transported Client #1 to the hospital. The GER summary noted the Emergency Room physician informed the Qualified Developmental Disability Professional (QDDP) Client #1 passed away. The QDDP reported medical staff removed a piece of meat from Client #1's throat.</p>			
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	<p>Review of Client #1's Information List revealed his diagnoses included, Moderate Intellectual Disability (ID), postural kyphosis, gastric ulcer, constipation, age related cataract, dry eye syndrome, hip and knee arthritis and benign prostatic hyperplasia (enlarged prostate/urinary frequency).</p> <p>Further record review revealed Client #1's Individual Support Plan (ISP) completed on 9/26/20. The ISP noted Client #1 was 61 years old, with an admission date of 9/23/20. The ISP identified Client #1 ate a general diet of soft consistency, cut in "bite sized pieces". In addition, the document noted Client #1 needed support and "supervision while consuming food".</p> <p>Record review on 3/16/21 revealed an Emergency/Urgent Care document summarizing the events leading to Client #1's arrival at the hospital and subsequent care provided on 12/1/20. According to the history section, Client #1 was a 61-year-old male with "special needs" brought in by EMS (Emergency Medical Staff) in full cardiac arrest with CPR in progress. EMS reported Client #1 was sitting at the table and staff witnessed him possibly choking when he stood up and collapsed. The summary noted staff at the facility attempted to</p>			
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	<p>do the Heimlich maneuver but were unable to get the foreign body out of his throat. The EMS staff arrived and pulled out a "big chunk of chicken" measuring approximately 4 x 3 centimeters (cm) at the base of Client #1's throat. Client #1 passed away at 1831.</p> <p>When interviewed on 3/15/21 at 4:00 p.m., the QDDP recalled she passed medications in the home at approximately 5:30 p.m. on 12/1/20. When she came out of the restroom after helping another client, she saw Client #1 sitting at the table with his plate of food, including a chicken patty sandwich cut in what she described as appropriate sized pieces. The QDDP recalled the TAS was at the stove, not at the table with Client #1 while he ate. The QDDP saw Client #1 stand and go to another table and heard gurgling sounds and noted drooling. She instructed the Temporary Agency Staff (TAS) to call 911 and she started the Heimlich maneuver. She asked Client #1 to stand and he eventually collapsed despite her abdominal thrusts. When on the floor the QDDP began CPR and provided it until the paramedics arrived. The QDDP confirmed staff should have eyes on Client #1 when he consumed food per his ISP. She confirmed hospital staff informed her they found a piece of chicken patty in Client #1's throat on 12/1/20.</p>			
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	<p>When interviewed on 3/15/21 at 5:15 p.m., the TAS confirmed she worked with Client #1 at House 755 on 12/1/20. She confirmed Client #1 required his food cut up "bite size" and defined it as the size of a nickel. She said she did not know why Client #1 required his meat cut and stated he did not need eyes on supervision. The TAS said staff just needed to be in the area when Client #1 ate. She said she had never been instructed to sit with him or to prompt him if he ate too fast or took too many bites at a time. The TAS recalled once she served Client #1 his plate, she returned to the counter to fix another client's plate. She said her back was to Client #1 when he ate. She recalled hearing the QDDP talking to Client #1, turned, and saw him in a different chair. She noted he was having difficulty breathing and the QDDP performed abdominal thrusts. The TAS said when Client #1 went to the floor she performed a finger sweep and removed some pieces of canned peach from his mouth. The TAS said she did not witness Client #1 take any bites of his sandwich because her back was to him. She acknowledged since she worked through another company, her training came verbally from other staff and estimated her training time as one hour for all individual clients in the home. The TAS acknowledged</p>			
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	<p>the facility provided some written documents in a binder and on the refrigerator for staff reference.</p> <p>On 3/15/21 the surveyor requested documentation of staff training on Client #1's dietary plan. The QDDP stated staff received verbal training from other staff but she would attempt to find documentation of the training provided.</p> <p>When interviewed on 3/16/21 at 10:25 a.m., the Supported Community Living Supervisor (SCLS) confirmed she worked on 12/1/20 due to regular staff calling off. She said other staff on duty included the TAS. She noted the QDDP came to pass medications. She recalled she helped Client #4 in the restroom and when she came out, Client #1 laid on the floor. She said the QDDP later told her she came out of the medication room and saw Client #1 get up and move to another table. The SCLS confirmed she saw Client #1 eating prior to entering the restroom with Client #4. She could not recall the size of his food but she noted no staff sat with him while he ate. She said she did not think staff had to supervise him while he ate. She said she had worked at the home prior to the incident but knew "very little" about Client #1.</p>			
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	<p>Record review on 3/17/21 revealed the SCLS User Learning document. The document noted the SCLS received training on multiple topics such as CPR, Mandt, Hand Hygiene and Donning and Doffing Personal Protective Equipment (PPE). The document lacked any documentation of training on Client #1's dietary guidelines.</p> <p>When interviewed on 3/16/21 at 11:30 a.m., the Shift Supervisor explained she trained staff by having them follow her, showing them what to do and then following them to observe them. She denied documenting training on ISPs. She confirmed staff needed to sit with Client #1 during meals because he would take more than one piece of food at a time and would overload his spoon.</p> <p>On 3/16/21 at 12:10 p.m., the QDDP produced documents with information regarding Client #1's diet. She noted the documents had been in a binder staff guidance regarding Client #1's diet. One document titled (Client #1's first and last name) directed staff to cut his food into ½ 'pieces. The sheet lacked information regarding supervision while he ate. The QDDP acknowledged she created the document. (Cross reference W159). A second document</p>			
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	<p>titled (Client #1's first name) noted his diet order as soft, bite size and high fiber. The document also directed staff to cut all food, including sandwiches and breads into ½-inch pieces. The QDDP stated she would continue to seek evidence of staff being trained on the documents.</p> <p>When interviewed on 3/17/21 at 11:15 a.m., the QDDP confirmed she could not produce documentation of the TAS or the SCLS being trained on Client #1's dietary guidelines prior to the incident on 12/1/20.</p> <p>When interviewed on 3/17/21 at 10:40 a.m., the QDDP stated a ½-inch bite should be the size of a dice. She said she had been trying to coordinate training with the facility dietician to better define each client's bite size, but no training had been completed at the time of the investigation.</p> <p>When interviewed on 3/22/21 at 8:50 a.m., the Registered Dietician (RD) confirmed she completed a Nutritional Assessment for Client #1. She said she usually looked at prior recommendations and apparently missed Client #1's history of ½-inch size bites. She acknowledged he needed help to cut his food into smaller pieces because he did not possess</p>			
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	<p>the strength and judgement to do so independently. She confirmed she recommended one-inch pieces so he would not get too big a bite. She confirmed 1.57 inches as the equivalent of a 4-centimeter (cm) piece of food. She noted a 4 x 3-cm. piece of food would not be safe for Client #1.</p> <p>2. When interviewed on 3/15/21 at 3:15 p.m., the Shift Supervisor stated staff needed to sit with Client #1 to make sure he took small bites and chewed before he took another bite. She defined his bite size pieces of food as the size of a small Lego.</p> <p>When interviewed on 3/16/21 at 9:35 a.m., the Registered Nurse (RN) confirmed she had observed Client #1 eat meals and noted his food should be cut bite size, ½ inch to 1 inch in size. She said the size of a small Lego or the size of a nickel should be acceptable. She noted staff should sit with him to make sure he drank his fluids.</p> <p>When interviewed on 3/16/21 at 11:40 a.m., Direct Support Professional (DSP) A said Client #1's food should be cut up into 1 inch by 1-inch pieces. She recalled staff sat by him to prompt him to scoop his food.</p>			
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	<p>When interviewed on 3/16/21 at 4:45 p.m., DSP C defined "bite size" as the size of a nickel. She acknowledged she did not work the night of the incident with Client #1 but noted he did not require supervision when he ate. She then stated that staff usually sat at the table with clients when they ate.</p> <p>When interviewed on 3/16/21 at 9:30 a.m., DSP D stated she was new to the facility and stated she received training on client diets. She said Client #2 required "bite size pieces" and defined bite size as the size of a nickel.</p> <p>Record review on 3/17/21 revealed a blank New Hire Orientation (NHO) Job Shadow Checklist. The Dietary section noted review of menus, grocery shopping, food storage, access to food and adaptive equipment. The document lacked any review of client dietary information.</p> <p>In summary, interviews with staff revealed varying levels of understanding of the term "bite size" and a lack of knowledge of Client #1's level of supervision during consumption of food.</p> <p>3. Observation on 3/16/21 from 5:30 p.m. - 5:50 p.m. revealed Client #2 sat at the table as staff prepared her meal. DSP C sat a bowl of</p>			
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	<p>macaroni and cheese on the table and walked away from her. DSP C failed to provide a non - skid mat or a plate riser to Client #2.</p> <p>Record review on 3/16/21 revealed Dietary Guidelines for the clients residing at House 755. According to the document, Client #2 used a non-skid mat, a rocker knife and a plate riser.</p> <p>When interviewed on 3/16/21 at 5:50 p.m., the QDDP confirmed staff should provide Client #2 a non-skid mat and a plate riser for ease in accessing her food.</p> <p>FACILITY RESPONSE:</p>			
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