9/29/17 OK

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G030	A. BUILDING _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM IOWA-CRESTWOOD	3944 CRESTWOOD DRIVE N W CEDAR RAPIDS, IA 52405

(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 At the time of the annual survey, investigation #69657-I was also conducted. Investigation #69657 resulted in a deficiency cited at W249.	W 000		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure guardian consent for use of behavior modifying medication. This affected 1 of 3 sample clients administered behavior modifying medication (Client #3). Findings follow: Record review on 8/23/17 revealed Client #3's Plan of Care (POC) developed by the interdisciplinary team on 5/31/17. The POC noted Client #3 received Seroquel and Fluvoxamine to assist in managing his/her behaviors. The team decision not to reduce Client #3's current medication included information regarding an increase in Seroquel in April 2016. According to the POC the facility failed to notify the family of the increase in Seroquel. When notified in March 2017, the family requested the Seroquel be decreased. Further record review revealed a Medication History Record. The record indicated Client #3 received 200 milligrams (mg) of Seroquel a day beginning 9/15/15. The record next noted an increase to 400 mg of Seroquel a day with a start	W 125	See attached. POC 10/25/17	

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

Traci M. Biddell, Program Director 09/25/2017

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 125	Continued From page 1 date of 3/21/16. Continued review revealed a copy of a memo to Client #3's Psychiatrist written by the facility Registered Nurse (RN), dated 3/15/17. The memo acknowledged an increase in Seroquel in April 2016 and the failure to inform the family of the increase. The RN requested consideration of a medication reduction. The Psychiatrist ordered a decrease in Seroquel back to 200 mg. a day. The facility failed to produce an informed consent document to administer 400 mg of Seroquel from April 2016 - March 2017. When interviewed on 8/23/17 at 1:42 p.m., the RN confirmed she discovered a discrepancy in the medication record while reviewing Client #3's record. She explained the previous nurse called and requested a medication increase due to Client #3 exhibiting more maladaptive behaviors. She said the nurse failed to inform any other interdisciplinary team members of the increase. When interviewed on 8/23/17 at 2:00 p.m., the Program Coordinator (PC) confirmed she spoke with Client #3's guardian and the guardian had no knowledge of the increase. She said the guardian requested a decrease in the medication.	W 125		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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	W 249		

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W 249	Continued From page 2 plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to consistently implement client individual program plans (IPP). This affected 2 of 4 sample clients including 1 of 1 client involved in investigation #69657-I (Client #1 and Client #4). Findings follow: 1. Record review on 8/21/17 revealed an Incident Internal Overview report signed by the Quality Improvement Specialist (QIS) on 7/25/17. The report noted on 7/15/17 at approximately 1:50 p.m. Client #1 paced the hallway at the facility. Direct Support Professional (DSP) A walked up the hallway and noticed the outside front door open. Staff discovered Client #1 left the building unsupervised. According to the report, Client #1's diagnoses included Profound Intellectual Disability, Autistic Disorder, Bipolar Disorder, Self-Injurious Behavior (SIB), PICA and Generalized Seizure Disorder. Further record review revealed Client #1's Individual Program Plan (IPP) to reduce acts of elopement/attempted elopement. The IPP identified not being engaged in an activity as a possible antecedent to elopement behavior. The IPP directed staff to prompt Client #1 to use the Put Em Around (communication device) each time he/she wanted to go outside and to know his/her whereabouts. The IPP documented additional information for staff to check on Client #1's approximately every 5 minutes to ensure his/her whereabouts and to ensure he/she had not eloped.	W 249		

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W 249	Continued From page 3 Observations at the home on 8/21/17 at 2:30 p.m. revealed bolt type latches on the front and back gates of the home. When interviewed on 8/21/17 at 2:35 p.m., the Program Coordinator (PC) said staff told her the gate was latched but not locked on the day of the incident. She confirmed staff found Client #1 sitting in Lead Direct Support Professional (LDSP) A's vehicle. When asked to explain Client #1's level of supervision, she stated staff should know his/her whereabouts. When interviewed on 8/21/17 at 4:30 p.m. DSP B confirmed she pulled in the driveway to work on 7/15/17 at approximately 1:50 p.m. and saw Client #1 sitting in LDSP A's vehicle. She further confirmed she saw DSP A and DSP C outside and assumed they were looking for Client #1. When interviewed on 8/22/17 at 9:45 a.m. DSP C confirmed he was assigned supervision of Client #1 on 7/15/17. He defined Client #1's level of supervision at the time as staff should keep an eye on Client #1 at all times. He recalled he was in the living room with several other clients while they watched a movie on television. He confirmed he didn't know Client #1 left the building until DSP A asked his/her whereabouts. He estimated he last saw Client #1 in the hall at 1:40 p.m. - 1:45 p.m. DSP C said he looked in all the bedrooms and then went outside to look for Client #1. He said he walked down the street and then back to the home (approximately one block). He then saw Client #1 in the parking lot with DSP B. When interviewed on 8/22/17 at 10:25 a.m. DSP	W 249		

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W 249	Continued From page 4 A confirmed she was helping a client clean his/her room in the back of the building on 7/15/17. She recalled seeing Client #1 "roaming" in the hall and later noticed the front door ajar. She asked about Client #1's whereabouts and DSP C didn't know. DSP A defined Client #1's supervision level as "within eyesight." She confirmed she went outside to look for Client #1 and within a few minutes saw DSP B walking with him/her in the driveway. When interviewed on 8/22/17 at 11:00 a.m. LDSP A stated he was working in the kitchen on 7/15/17 and came out when he heard DSP A ask DSP C Client #1's whereabouts. He stated Client #1 "should've been within someone's eyesight." He estimated he saw Client #1 about 10 minutes before he heard DSP A ask about him/her. When interviewed on 8/22/17 at 11:35 a.m. the Program Coordinator (PC) confirmed staff reported Client #1 eloped when she arrived to work on 7/22/17 at 2:00 p.m. She recalled staff recently informed her Client #1 learned how to unlock the gate. She said she reported the discovery to her boss and verbally directed staff to keep an eye on Client #1. When interviewed on 8/22/17 at 2:55 p.m. the QIS confirmed she participated in the investigation of Client #1's elopement on 7/15/17. She defined Client #1's level of supervision at the time as staff required to know his/her whereabouts. She confirmed staff failed to follow his/her established level of supervision on 7/15/17. 2. Observation on 8/22/17 at 6:45 a.m. revealed Client #1 sat in a chair in the dining room. The	W 249		

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W 249	Continued From page 5 Registered Nurse (RN), LDSP A and DSP A walked in and out of the area. No staff wore a colored bracelet. Observation at 7:45 a.m. revealed Client #1 sat at the table in the dining room and ate breakfast. LDSP A sat with him/her. He wore no colored bracelet. Client #1 got up and walked down the hall with the RN. DSP C stood outside on the back patio wearing the colored bracelet. When asked Client #1's whereabouts, DSP C stated he/she "should be in the dining room." He confirmed he didn't know Client #1's whereabouts. He further confirmed staff responsible for supervision of Client #1 wore a colored bracelet and noted the bracelet on his wrist. Record review on 8/22/17 revealed Client #1's IPP to reduce acts of elopement, revised on 7/19/17. The program noted the person responsible for knowing Client #1's whereabouts should wear a colored bracelet on their wrist. When interviewed on 8/21/17 at 3:45 p.m. LDSP B confirmed staff wore a colored bracelet to acknowledge supervisory responsibility for Client #1. She noted staff should pass the bracelet to another staff if necessary to assure his/her supervision level is maintained. 3. Observation on 8/22/17 at 9:10 a.m. revealed Client #1 walked out the front door to get on the van to go to the day program. DSP C walked with him/her past the Put Em Around communication device. DSP C failed to prompt Client #1 to push the device. Observation on 8/23/17 at 8:55 a.m. revealed	W 249		

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W 249	Continued From page 6 Client #1 walked past the RN, out the back door onto the patio. She failed to prompt him/her to press the Put Em Around to indicate he/she wanted to go outside. Further observation on 8/23/17 at 9:20 a.m. revealed Client #1 walked out the front door to get on the van to go to the day program. Staff in the area failed to prompt him/her to use the device on the wall to indicate he/she wanted to leave the building. Record review on 8/22/17 revealed Client #1's IPP to reduce elopement included direction to staff to prompt Client #1 to use the Put Em Around communication device each time he/she left the building. When interviewed on 8/23/17 at 10:30 a.m. the Qualified Intellectual Disability Professional (QIDP) confirmed staff should prompt Client #1 to use the communication devices each time he/she went outside so he/she would learn to notify staff he/she wanted to leave the building. 4. Observation at REM Developmental Services (RDS), the day program on 8/22/17 at 2:30 p.m. revealed DSP D drank from a large cup (approximately 32 ounces). She placed the cup on a table and walked away to assist a client. Client # 4 walked to the table and drank from the cup. DSP E approached him/her, verbally prompted "spit it out" and squeezed Client #4's cheeks. Client #4 spit liquid and ice into the cup. Record review on 8/23/17 revealed Client #4's IPP to refrain from consuming unscheduled liquids. The program noted possible antecedents to the behavior included liquids being left out in	W 249		

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W 249	Continued From page 7 the open. De-escalation techniques included increasing staff supervision and putting all liquids away. Interventions included staff implementation of de-escalation techniques, directing Client #4 to take a break in a quiet area, providing him/her with a direct verbal prompt (e.g. it's not time for liquids) and blocking his/her consumption. The IPP noted day program staff should follow the same interventions as described for the home setting. Interventions did not include squeezing Client #4's cheeks. When interviewed on 8/23/17 at 12:25 p.m. the QIDP confirmed staff should have followed the IPP and verbally prompted Client #4 not to consume liquids. He stated staff should not squeeze his/her cheeks. When interviewed on 8/23/17 at 12:55 p.m. the PC stated staff should not squeeze Client #4's cheeks and should not leave drinks out in front of him/her per the IPP.	W 249		
W 348	483.460(e)(1) DENTAL SERVICES The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure clients received dental treatment services as recommended. This affected 1 of 4 sample clients (Client #3). Findings follow:	W 348		

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W 348	Continued From page 8 Record review on 8/23/17 revealed Client #3's dental examination form, dated 7/12/16. The form indicated Client #3 should return for a six month recall. Further record review revealed no dental examination since 7/12/16. When interviewed on 8/23/17 at 1:40 p.m. the Registered Nurse (RN) confirmed staff failed to make a follow up appointment for Client #3.	W 348		

V 9/29/17

Accept this plan as the facilities credible allegation of compliance.

Tag W 125: **Facility Response:** The facility Program Director, Nursing Director, and/or QIDP will retrain facility Program Coordinators, Lead DSPs, and Program Nurses on the correct procedure regarding changes in behavior modifying medications, specifically focusing on the requirement of obtaining consents from clients guardian(s) and the Human Rights Committee (HRC) members prior to implementing changes outside of a medication approval range. This training is included in the orientation for all new nurses. To ensure that compliance is maintained and monitored, restrictive measures are reviewed at least annually during the Plan of Care process and bi-annually in conjunction with the HRC meetings. There are also other random reviews that may be conducted throughout the year by the Nursing Director (two charts, twice per year) and/or the Quality Improvement Specialist.

Tag W 249: **Facility Response:** The facility QIDP, Program Coordinator, Lead DSP and/or Program Director will provide retraining to residential and day program staff on Client #1's IPP1A regarding elopement and to day program staff on Client #4's IPP1A regarding unscheduled beverage consumption, which will include proper interventions. Supervisors and/or designees at the residential program will complete programmatic observations for Client #1's IPP1A at home a minimum of twice monthly to ensure that the program is being implemented as written and specifically ensuring the methods to maintain appropriate supervision are being followed. Supervisors and/or designees at the day program and/or the facility QIDP will complete programmatic observations for Client #4's IPP1A at the day program a minimum of twice monthly to ensure that the program is being implemented as written. These observations will continue until the facility deems that they are no longer necessary at this frequency based on compliance. Programs will be reviewed monthly by the facility QIDP as part of the data summary process and will be evaluated for revisions to meet client needs. When revisions are made, staff will be trained on these revisions in both locations as applicable. Client programming will continue to be reviewed monthly at staff meetings in both locations on an on-going basis to maintain and monitor compliance.

Tag W 348: **Facility Response:** The facility Program Nurse will maintain a tracking sheet for required appointments which will be periodically reviewed by the Nursing Director to ensure compliance with clients attending needed appointments. In the absence of a Program Nurse, maintenance of the appointment tracking sheet will be assigned to the facility Program Coordinator, Lead DSP, or designee to ensure necessary medical appointments are not missed. Training on the appointment tracking sheet is included in the orientation for all new nurses. To ensure on-going compliance is maintained and monitored, there are random nursing reviews that may be conducted throughout the year by the Nursing Director (two charts, twice per year).

Completion Date: 10/25/2017