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	16G139	A. BUILDING ______ B. WING ______	03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANAGER PLACE	2309 C STREET SW CEDAR RAPIDS, IA 52404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The annual health facility survey resulted in a determination of Immediate Jeopardy (IJ) on 3/04/21 at 3:00 p.m. based on multiple incident reports of client head banging episodes, with inadequate nursing assessment or follow-up. Two sample clients had multiple incident reports regarding banging their heads on hard surfaces. Record review revealed staff typically did not contact nursing staff. Nursing notes related to the incidents could not be found, with the exception of two instances when a client went to the emergency room after showing signs of a possible concussion. The facility developed and implemented a plan of abatement to develop a head injury policy and retrain staff regarding head injury protocol, which included notifying nursing staff of head injuries. The IJ was removed on 3/10/21 at approximately 12:00 p.m. A Conditional Level Deficiency was cited at W318. Standard Level Deficiencies were cited at W331, W337 and W371, related to W318. Additional deficiencies were cited related to the health facility survey.	W 000	See Attached POC 5/17/21	
W 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124		

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

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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This STANDARD is not met as evidenced by:
Based on interviews and record review, the facility failed to obtain written informed consent for behavior modifying medications, which included updated medications and potential medication side effects. This affected 4 of 4 sample clients (Client #1, Client #7, Client #12 and Client #17). Findings follow:

1. Record review on 3/03/21 and 3/04/21 revealed Client #1's Individual Program Plan (IPP) to address target behaviors of physical aggression, verbal aggression, self-injurious behavior and elopement. The IPP included multiple restrictive measures, including behavior modifying medication. According to Client #1's Physician's Orders dated 3/01/21, she took behavior modifying medication as follows: clonidine 0.1 mg daily, guanfacine 2 mg three times per day (6 mg total), lamotrigine 100 mg twice per day (200 mg total), trazodone 150 mg per day and ziprasidone 80 mg twice per day (160 mg total).

Client #1 was admitted to the facility on 7/13/20. Written informed consent for restrictive measures was signed by the guardian on 7/13/20 and by a member of the Human Rights Committee (HRC) on 7/18/20. The medications listed in the consent were as follows: guanfacine 1 mg twice per day (2 mg total), lamotrigine 25 mg twice per day (50 mg total), trazodone 50 mg daily, ziprasidone 40 mg in the morning and 80 mg in the evening (120 mg total). The written consent listed the exact dosages of the medication and not a dosage range. Clonidine was not included in the list of medications. The consent did not contain any

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information regarding possible risks or side effects of the medications.

Based on review of the written informed consent developed in July 2020 and the Physician's Orders dated 3/01/21, all of Client #1's behavior modifying medications at admission had been increased and a new medication (Clonidine) had been added.

When interviewed on 3/03/21 at 3:15 p.m. Qualified Intellectual Disability Professional (QIDP) A stated the facility did not include the risks/side effects in the consent for the medications already in place at the time of the admission. QIDP A also said she had not obtained updated written informed consents or notified the guardian or HRC members when the medications were increased. QIDP A said she obtained email consent from the guardian and an HRC member for the addition of the Clonidine in late July 2020, but not written consent.

As of 3/16/21 the emails from Client #1's guardian and the HRC member regarding consent for the Clonidine had not been provided.

2. Record review on 3/04/21 and 3/08/21 revealed Client #7's IPP to address target behaviors of physical aggression, verbal aggression, emotional outbursts and self-injurious behavior. Client # 7's IPP included multiple restrictive measures, including behavior modifying medication.

Additional record review revealed an updated written informed consent for restrictive measures for the period of 12/07/2020 to 12/07/2021. The

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W 124	Continued From page 3 consent was signed by the guardian on 1/06/21 and by two HRC members on 1/08/21. The consent listed dosage ranges for Client #7's medications, which included adderall, divalproex, guanfacine, olanzapine, fluoxetine and trazodone. Client #7's current behavior modifying medications were within the ranges noted on the written consent other than lithium, which had been added on 2/26/21. A separate consent had been obtained for the lithium. The consents provided no information regarding potential risks/side effects of the medication. When interviewed on 3/10/21 at 10:00 a.m. QIDP A stated she had not provided information to the guardian or HRC members regarding potential risks/side effects of the behavior modifying medications with the annual written informed consent developed in December 2020. She said she obtained phone and/or email consent for the Lithium on 2/26/21 and was currently still working on getting written consent. QIDP A said she didn't remember if she sent information to the guardian or HRC members regarding possible risks/side effects of the Lithium. 3. Record review on 3/03/21 and 3/04/21 revealed Client #17's IPP to address target behaviors of physical aggression, verbal aggression, and property destruction. Client #17 had a variety of restrictive measures in place, including behavior modifying medication. Client #17's Physician's Orders dated 3/04/21 listed his current behavior modifying medication as Vyvanse 60 mg each morning; Risperidone 2 mg twice per day (4 mg total) and Guanfacine 3 mg at bedtime.	W 124		

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W 124	Continued From page 4 Client #17 was admitted to the facility on 5/22/20 and written informed consent for restrictive measures was signed by the guardian on 5/22/20 and by two members of the Human Rights Committee (HRC) on 7/13/20. The medication section of the written consent did not list the medication and instead noted, "continue current medications at admit." The consent did not contain any information regarding possible risks or side effects of the medications. The medications at the time of admission were as follows: Vyvanse 30 mg daily, Risperidone 2.5 mg daily, and Guanfacine 3 mg at bedtime. Based on review of the written informed consent developed in May 2020 and the Physician's Orders dated 3/04/21, Client #17's Vyvanse and Risperidone had been increased since the admission date, but the written informed consent had not been updated. 4. Record review on 3/04/21 revealed Client #12's IPP to address target behaviors of physical/sexual aggression, verbal aggression/sexualized language/sexualized gestures, self-harm-head banging, and self-harm-biting wrists. Client #12's IPP included multiple restrictive measures in place, including behavior modifying medication. His most recent written informed consent for restrictive measures was signed by the guardian on 5/6/20 and by two members of the Human Rights Committee (HRC) on 5/28/20. The medications listed in the consent were as follows: Risperidone, range 0-60 mg; Melatonin, range 0-10 mg; Concerta, range 0-72 mg; Lithium, range 0-900 mg; Ritalin, range 0-30 mg and Jornay, range 0-60 mg. The consent did not contain any information regarding possible	W 124		

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W 124	Continued From page 5 risks or side effects of the medications.	W 124		
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 interview and record review, the facility failed to report all allegations of abuse in a timely manner. This pertained to 1 of 7 clients involved in allegations of abuse since 1/01/2020 (Client #6). Finding follows: Record review on 3/01/21 revealed a facility investigation regarding an allegation of abuse made by Client #6 on 9/24/20. According to the facility investigation, Client #6 became aggressive toward Youth Service Worker (YSW) A on the morning of 9/24/20. YSW A said her fingernail accidentally scratched Client #6's arm as she raised her hands up to block Client #6 from hitting her in the face. Client #6 began crying and said YSW A had purposefully scratched him. The facility separated YSW A from Client #6 and conducted an internal investigation. According to additional documentation, the facility reported the allegation of abuse to the Department of Human Services (DHS) and the Department of Inspections and Appeals (DIA) on 10/08/20, which was approximately two weeks after the incident. The facility reported the incident to DHS because the client was a minor. DHS accepted	W 153		

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the abuse report for assessment and determined it to be not confirmed and not placed.

When interviewed on 3/01/21 at 2:45 p.m. the Health and Practice Manager confirmed the facility did not immediately report the allegation of abuse. She said the agency had done some management staff restructuring around the time of the incident on 9/24/20 and the facility failed to immediately report the allegation due to an oversight.

According to the agency Abuse Prevention policy, allegations of child abuse should be reported to DHS not later than 24 hours or the next business day. The policy further indicated the facility would notify DIA of a suspicion of a crime against a client within 24 hours or the next business day.

When interviewed on 3/09/21 at 4:50 p.m. the Vice President of Operations reported the facility should report allegations of child abuse to DIA within 24 hours or the next business day based on their policy to report suspicion of a crime against a client.

W 159 QIDP
CFR(s): 483.430(a)

Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.
This STANDARD is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to ensure a Qualified Intellectual Disability Professional (QIDP) monitored individual program plans, reviewed incident reports, and incorporated professional recommendations into client programs. This

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affected 2 of 2 sample clients in Terry Cottage (Client #12, Client #17). Finding follows:

1. Observations at Terry Cottage on the afternoon of 3/01/21 and the mornings of 3/02/21 and 3/03/21 revealed multiple behavioral incidents involving several of the clients, including Client #12 and Client #17. Behaviors included aggression, inappropriate sexual behavior, self-injurious behavior and inappropriate verbal interactions. During the periods of observation, no QIDP was present at the cottage.

Record review on 3/03/21 revealed Client #17's monthly program data summaries in his chart through October 2020, completed by QIDP B, who left the facility in December 2020.

Additional record review on 3/04/21 revealed Client #12's monthly program data summaries in his chart through October 2020, completed by QIDP B. Current data reviews could not be located in the charts. The facility provided the requested program data reviews for November 2020, December 2020 and January 2021 on the afternoon 3/04/21. The Health and Practice Manager (HPM) acknowledged QIDP A and QIDP C just recently completed the data reviews for November 2020 through January 2021, after the surveyor requested them. The program data had not been reviewed by a QIDP since QIDP B left the agency in December. Programs had not been reviewed for possible revision based on client performance. Client #12 and Client #17 had significant behavioral challenges addressed by Individual Program Plans, which were not reviewed during this three month period. Both clients were also on behavior modifying medications, which had been reviewed by the

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psychiatrist for dosage changes during this time period.

2. Record review of the program data summaries on 3/08/21 revealed data for Client #12's program to wear his glasses. The data indicated Client #12 did not wear his glasses during November 2020, December 2020 and January 2021 because they were broken. The summaries revealed no follow up completed by a QIDP regarding the broken glasses. The program data summaries also lacked the signature of a QIDP.

When interviewed on 3/11/21 at 1:05 p.m. the HPM and the ICF/ID Program Manager stated the QIDP should be responsible for reviewing progress of the Individual Program Plans and revising them as needed.

3. Record Review on 3/04/21 of incident reports from December 2020 to February 2021 for Client #12's behavioral incidents revealed none of the reports had been reviewed by a QIDP. Client #12 had significant behavioral issues, including episodes of head banging and a history of concussions.

When interviewed on 3/11/21 at 11:50 a.m. the HPM said the facility had contracted with a QIDP for Terry Cottage, but she was unsure if it was the contracted QIDP's responsibility to review incident reports for Client #12 or the other clients at Terry Cottage. During a follow-up interview on 3/11/21 at 12:54 p.m. the HPM confirmed there was no QIDP review on incident reports since December 2020 for Client #12

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4. Record review on 3/03/21 revealed Client #17 received an occupational therapy (OT) evaluation on 2/02/21. The OT evaluation included recommendations of using a weighted blanket, use of Lycra sheets, trial the use of headphones for loud noises, providing a bin of paper to rip up when upset and a bin of toys to take apart, offering a fidget device and encourage heavy work. The evaluation also suggested other various exercises and activities. Observations 3/1/21 - 3/3/21 revealed the suggested items and/or activities were offered.

Continued record review revealed the recommendations had not been incorporated into Client #17's program plans or active treatment schedule.

When interviewed on 3/16/21 at 10:30 a.m., the HPM and ICF/ID Program Manager stated the facility currently worked toward implementing recommendations made in Client #17's OT evaluation.

W 191 STAFF TRAINING PROGRAM W 191
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 competently implemented interventions to address client behavioral needs. This affected 1 of 4 sample clients (Client #12), one client added to the sample (Client #13).

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1. Observation at Terry Cottage on 3/03/21 at 7:32 a.m. revealed Youth Service Worker (YSW) C and the Terry Cottage Assistant Supervisor (TAS) inappropriately physically escorted Client #12. YSW C and the TAS stood on each side of client #12 and held onto his arms. YSW C and the TAS each had one of their hands on Client #12's upper arm and one hand on Client #12's lower arm as they escorted the client to his room from the staff desk area.

When interviewed on 3/03/21 at 7:42 a.m. YSW D stated during an approved physical escort, staff should have one hand on the client's hip and the other hand on the client's opposite elbow. When interviewed on 3/03/21 at 7:53 a.m. the TAS stated the interaction observed at 7:32 a.m. was an escort and not a hold. The TAS demonstrated a Mandt hold for the surveyor at time of interview to show the difference between an escort and a hold.

2. Observation at Terry Cottage on 3/02/21 at 7:06 a.m. revealed YSW B inappropriately escorted Client #13. YSW B stood behind client #13 with both hands on Client #13 upper arms. YSW B escorted Client #13 away from Client #12's bedroom. YSW B released her hands from Client #13's upper arms when the client dropped to the floor.

When interviewed on 3/03/2021 at 10:30 a.m. the Health and Practice Manager (HPM) and ICF ID Program manager (PM) demonstrated a physical escort with one hand on the person's elbow and the other hand on the opposite waist. The PM stated the facility did not consider physical escorts to be a restraint and did not require them to be documented as a restraint because they did

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W 191	Continued From page 11 not restrict the client's movement. However, the two interactions observed by the surveyor on 3/02/21 and 3/03/21 did appear to restrict the clients' freedom of movement. Record review on 3/04/21 of the facility behavior policy described personal escort as, "during an escort one hand is placed just above the elbow and the other hand is placed on the client's opposite hip."	W 191		
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 correctly implemented physical escorts. This affected 1 of 4 sample clients (Client #12), one client identified during the investigation of #96136-I (Client #6) and one non-sample client (Client #13). 1. Observation at Terry Cottage on 3/03/21 at 7:32 a.m. revealed Youth Service Worker (YSW) C and the Terry Cottage Assistant Supervisor (TAS) inappropriately physically escorted Client #12. YSW C and the TAS stood on each side of client #12 and held onto his arms. YSW C and the TAS each had one of their hands on Client #12's upper arm and one hand on Client #12's lower arm as they escorted the client to his room from the staff desk area. When interviewed on 3/03/21 at 7:42 a.m. YSW D stated during an approved physical escort, staff should have one	W 193		

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hand on the client's hip and the other hand on the client's opposite elbow. When interviewed on 3/03/21 at 7:53 a.m. the TAS stated the interaction observed at 7:32 a.m. was an escort and not a hold. The TAS demonstrated a Mandt hold for the surveyor at time of interview to show the difference between an escort and a hold.

Observation at Terry Cottage on 3/02/21 at 7:06 a.m. revealed YSW B inappropriately escorted Client #13. YSW B stood behind client #13 with both hands on Client #13 upper arms. YSW B escorted Client #13 away from Client #12's bedroom. YSW B released her hands from Client #13's upper arms when the client dropped to the floor.

When interviewed on 3/03/2021 at 10:30 a.m. the Health and Practice Manager (HPM) and ICF ID Program manager (PM) demonstrated a physical escort with one hand on the person's elbow and the other hand on the opposite waist. The PM stated the facility did not consider physical escorts to be a restraint and did not require them to be documented as a restraint because they did not restrict the client's movement. However, the two interactions observed by the surveyor on 3/02/21 and 3/03/21 did appear to restrict the clients' freedom of movement.

Record review on 3/04/21 of the facility behavior policy described personal escort as, "during an escort one hand is placed just above the elbow and the other hand is placed on the client's opposite hip."

2. Record review on 3/8/21 revealed Client #6's Incident Report (IR) dated 1/20/21. According to the IR, Client #6 engaged in physically aggressive

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behaviors and Youth Service Worker (YSW) F "escorted" him to his room.

Record review on 3/9/21 revealed Client #6's Individual Program Plan (IPP) to learn and utilize healthy and effective emotion regulation skills. The IPP addressed Client #6's physical aggression and directed staff to ask him to take a break, and if the aggression continued, to escort him to a safe place.

Observation on 3/9/21 revealed a video recording of the incident involving Client #6 and YSW F on 1/20/21. Viewing of the video revealed Client #6 struck YSW F in the face twice and YSW F grabbed his wrists, got behind him and walked with him down the hall still holding his wrists.

When interviewed on 3/9/21 at 8:10 a.m., YSW G confirmed she worked with Client #6 and described an escort as staff putting a hand on his elbow and the other hand on his opposite hip, and then guiding him to a safe place, usually his bedroom.

When interviewed on 3/9/21 at 1:35 p.m., the Sinclair Cottage Assistant Supervisor (SAS) stated he worked with Client #6 and confirmed he engaged in physical aggression toward staff. He said staff should repeat prompts to take a break and escort him to a safe place. He described an escort as staff placing a hand on Client #6's elbow and another hand on his opposite hip. The SAS indicated holding or grabbing Client #6's hands/wrists during an escort would not be an acceptable technique.

When interviewed on 3/9/21 at 4:35 p.m., the Sinclair Cottage Supervisor confirmed knowledge

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of Client #6's physical aggression and said staff should escort him if/when his aggression escalated to harming himself or others. She described an escort as staff placing a hand on his elbow and a hand on his hip to guide him to safety. She said grabbing and holding Client #6 by his wrists would not be an appropriate technique to escort him down the hall.

When interviewed on 3/10/21 at 8:10 a.m., the Health and Practice Manager (HPM) confirmed she viewed the video of the incident between Client #6 and YSW F. She confirmed YSW F placed his hands on Client #6's wrists and failed to use an approved technique when Client #6 aggressed toward him on 1/20/21.

W 216 | INDIVIDUAL PROGRAM PLAN | W 216

CFR(s): 483.440(c)(3)(v)

The comprehensive functional assessment must include physical development and health.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to obtain physicals in a timely manner for 1 of 2 sample clients admitted in the past year (Client #1). Finding follows:

Record review on 3/03/21 and 3/04/21 revealed Client #1 was admitted to the facility on 7/13/20. Continued record review revealed no evidence of Client #1 having a physical prior to admission or within the first 30 days. Client #1's physical with a physician was completed on 10/14/20.

When interviewed on 3/10/21 at 2:30 p.m. the Health and Practice Manager (HPM) stated the

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W 216	Continued From page 15 nursing staff did the health assessments for new admissions. The nursing staff did not include an Advanced Registered Nurse Practitioner. The agency physician signed the ICF/ID Level of Care and prescribed the medications, but did not do the client physicals. A local health clinic did the client physicals. The HPM did not have an explanation as to why Client #1's physical was done three months after her admission.	W 216		
W 217	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to assess nutritional/dietary needs in a timely manner for 2 of 2 sample clients admitted in the past year (Client #1 and Client #17). Finding follows: 1. Record review on 3/03/21 and 3/04/21 revealed Client #1 was admitted to the facility on 7/13/20. Her initial dietary evaluation was completed on 12/05/20. Client #1's Comprehensive Functional Assessment (CFA) completed on 7/13/20 included no dietary/nutrition information. 2. Record review on 3/03/21 revealed Client #17 was admitted to the facility on 5/22/20. His initial dietary evaluation was completed on 12/12/20. Client #17's CFA, dated 6/18/20, contained no dietary/nutrition information. When interviewed on 3/03/21 at 3:00 p.m. the	W 217		

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W 217	Continued From page 16 Health and Practice Manager (HPM) reported the facility's contract dietician resigned her position in the spring of 2020 and the facility did not hire another contract dietician until December 2020. As a result, no dietary assessments or services were completed during that time. The HPM provided emails which revealed the previous contract dietician notified the agency on 3/02/20 she would be unable to do in-patient consultations at the facility as of 4/01/20. In a follow-up email dated 4/07/20, the dietician indicated she would continue to provide services through the month of April in order to give the agency time to find a replacement. There were additional emails with a prospective dietician, who ultimately declined the position in July 2020. The HPM provided internal emails in October 2020 between agency management staff noting a dietician was still needed, but the agency provided no additional information regarding actively searching for a dietician.	W 217		
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 consistent	W 249		

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implementation of an Individual Program Plan (IPP) for behavior management and/or adaptive equipment for behavior. This affected 1 of 4 sample clients (Client #12) Findings follow:

1. Observation at Terry Cottage on 3/01/21 from 3:57 p.m. to 4:23 p.m. revealed Client #12 had ongoing episodes of cursing, yelling, punching the wall, and head banging on the wall and window. Client #12 did not wear his soft shell helmet and staff did not prompt him to wear it during the observation. On 3/01/21 at 3:57 p.m. Shift Lead A talked about setting a timer for Client #12 for a break and it would start over if he continued. On 3/01/21 at 4 p.m. Terry Assistant Supervisor (TAS) used the blocking pads to prevent Client #12 from exiting Terry Cottage. On 3/01/21 at 4:15 p.m. Client #10, Client #16, and Client #11 approached the front door area without redirection from staff as Client #12 was escalated by the front door. On 3/01/21 at 4:15 p.m. Client #12 was banging his head on the window. TAS blocked him with Ukeru blocking pads after Client #12 hit his head two times. TAS and a Person with Mental Illness-Children (PMIC) Supervisor attempted to change the subject and/or told Client #12 no if he talked about going outside or doing other recreational activities.

Continued observation at Terry Cottage on 3/02/21 from 7:34 a.m. to 7:53 a.m. revealed Client #12 and Client #13 had ongoing episodes of making sexual noises, sexual comments, and pelvic thrusting. On 3/02/21 at 7:34 a.m. and 7:37 a.m. Client #12 hit Client #13. On 3/02/21 at 7:43 a.m. Client #12, located in the bathroom, and Client #13, located on the lower level, made sexual noises to one another without staff intervention. On 3/02/21 at 7:45 a.m. Client #13

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W 249	Continued From page 18 opened the door of the bathroom and made a pelvic thrust motion to the door. Youth Service Worker (YSW) B redirected Client #13 when Client #12 opened the bathroom door showing Client # 13 and Client #17 his fully naked body. YSW B covered Client #13 eyes and prompted Client #12 to shut the door. Client #17 saw Client #12 naked and walked toward the door to throw an item at the door as Client #12 shut the door. On 3/02/21 at 7:48 a.m. Client #13 walked to the bathroom door of Client #12 and she made sexual noises up against the bathroom door. Client #14 approached Client #13 from behind and placed both hands on Client #13 upper arms. Client #14 pulled Client #13 away from the bathroom door. YSW B intervened and redirected Client #13 to the upper level. Client #12 opened the door four times showing his naked body to the common area and made sexual comments to Client #13. Client #17 walked from upper level to common area bathroom and told Client #12 not to show himself to Client #13. Additional observation at Terry Cottage on 3/03/21 from 7:12 a.m. to 7:51 a.m. revealed Client #12 declined to take a shower. Client #12 walked around the upper level and common area of the cottage. On 3/03/21 at 7:30 a.m. Client #12 climbed on the top of the couch and pelvic thrusted the wall. The TAS prompted Client #12 that he had 30 seconds to get down before escorted. Client #12 took longer than 30 seconds and he jumped off the couch. On 3/03/21 at 7:32 a.m. Client #12 was behind the staff desk on the upper level with the TAS and YSW C. Client #12 hit TAS and took the marker from the staff area. The TAS and YSW C escorted Client #12 to his room. Client #12 walked back out of his room and pushed into the TAS with his body. Client #12	W 249		

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then had a pen and used a stabbing motion to TAS' upper arm. Client #12 hit TAS and YSW C intervened and blocked for the TAS. Client #12 picked up a large storage bin lid and hit the TAS with the lid. The TAS and YSW C intervened and blocked the behavior. Client #12 then picked up Ukeru blocking pad and hit staff with the blocking pad, as he cursed and laughed at staff. Staff continued to prompt Client #12 to the shower.

2. Record Review on 3/04/21 of the Individual Program Plan (IPP) revealed Client #12 procedures for the following target behaviors: verbal aggression, sexualized language, sexualized gestures, physical and/or sexualized aggression, self- harm of head banging, and self-harm of biting wrists.
The IPP provided the following interventions:

a. The IPP for verbal aggression/sexualized language/sexualized gestures directed staff to firmly redirect Client #12 by stating "Your words/body unsafe, please stop." Staff should provide Client #12 time to process the direction and make a decision. If behaviors continued staff should direct Client #12 to take a time away where he chooses and staff feel is appropriate. When Client #12 follows through, he should be praised for making a safe choice.

The IPP directed staff should use the phrase "your words are unsafe, please stop". On 3/02/21 the surveyor observed Client #12 use sexual language toward Client #13, without staff using the above intervention from the IPP.

b. Client #12's IPP for physical aggression indicated staff should ask Client #12 to take a break in the location of his choice. Staff should

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remind (Client #12) that his break will last only until he is calm and give him a time from (1-2) minutes to make a choice. If the client continued to be aggressive and presented a danger to himself or others and danger was imminent, staff should escort/guide him to a safe place: away from "triggers." If aggression continued and Client #12 became physically aggressive during escort, staff should offer blocking pads to prevent injury to self or others. Should blocking pads be unavailable or ineffective, and Client #12 continued to engage in physical or sexualized aggression presenting an imminent danger to himself and/or others, staff will offer Mandt Restraint (not exceeding 15 minutes, with LP order) to keep him and others safe.

c. Client #12's IPP for self-harming indicated staff should firmly tell Client #12 to stop engaging in observed self-harming behavior. If he continued or attempted to continue to bang his head, staff should offer blocking pads to minimize risk of injury and intensity of impact. should blocking pads be unavailable or ineffective, staff should intervene physically to keep him safe, using proper Mandt restraint if necessary (with LP order), notifying QIDP if appropriate.

d. According to the IPP, Client #12 was prescribed a soft helmet to prevent head injury. The IPP directed each morning and throughout each day, if Client #12 did not wear his soft helmet, staff should provide him with an indirect cue. If Client #12) continued to refuse, staff should prompt him at least every 30 minutes until he put his helmet on.

Based on observations on 03/01/2021, 03/02/2021, and 03/03/21 staff did not prompt

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Client #12 to wear his helmet as directed in the IPP.

Additional record review of Incident Reports (IRs) on 3/04/21 revealed the following:
a. On 2/20/21 at 7:45 p.m. Client #12 was escalated and head banging walls and doors. The IR revealed no documentation of helmet use or Mandt hold. Staff escorted Client #12 to his room, which escalated him, per the IR. His head banging resulted in 2 sores on the front/top of his head.

b. On 2/11/21 at 2 p.m. Client #12 escalated and banged his head with high intensity on the wall. The IR noted the need to have blocking pads closer. The incident resulted in a "big red mark in the middle of forehead."

c. On 12/31/20 at 11:30 a.m. Client #12 banged his head on the wall. The incident resulted in a visible red mark on forehead.

d. On 12/28/20 at 12 a.m. staff escorted Client #12 to room his due to trying to hit staff. Client #12 engaged in self-harm by his biting wrists and head-banging against walls, floors, and doors with high intensity. The staff utilized Ukeru blocking pads and body positioning to prevent further harm, but Client #12 continued to engage in behavior. The incident action taken by staff included the blocking pads, fresh face, break, water, and space.

e. On 12/27/20 at 7:55 p.m. the IR revealed Client #12 was in an escalated state for about thirty minutes. He head banged approximately 20 times on the left and right side of his head at the wall. The incident action taken by staff included Ukeru

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W 249	Continued From page 22 head-blocking pads and staff used hand gestures. 3. When interviewed on 3/08/21 at 4:04 p.m. the Health and Practice Manager (HPM) confirmed Client #12 was not placed in any Mandt holds for the month of December 2020, January 2021, and February 2021. When interviewed on 3/11/21 at 1:05 p.m. the HPM and the ICF/ID Program Manager confirmed staff should follow Client #12's Individual Program Plan (IPP) for behavior management. 4. In summary, based on observations on 3/01/21, 3/02/21, and 03/03/21 the IPP for behavior management was not followed as written. The staff did not utilize the soft shell helmet as noted in Client #12's IPP. The incident reports for the months of December 2020, January 2021, and February 2021 indicated the IPP interventions were not followed as written for Client #12's ongoing head banging episodes which resulted in red marks and injury to Client #12's head.	W 249		
W 316	DRUG USAGE CFR(s): 483.450(e)(4)(ii) Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to attempt to decrease behavior modifying medication or provide justification for lack of medication decrease. This affected 1 of 2 sample clients who resided at the facility for over one	W 316		

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year (Client #7). Finding follows:

Record review on 3/04/21 and 3/08/21 revealed Client #7 was prescribed behavior modifying medications of adderall, divalproex, prozac, guanfacine, trazodone and olanzapine. No record of a medication reduction could be located in Client #7's chart for the past year.

When interviewed on the afternoon of 3/09/21, the Health and Practice Manager confirmed Client #7 had no reduction of behaving modifying medication in the past year and no documented team discussion regarding justification for not attempting an annual reduction.

W 318 HEALTH CARE SERVICES W 318
CFR(s): 483.460

The facility must ensure that specific health care services requirements are met.

This CONDITION is not met as evidenced by:
Based on interviews and record reviews, the facility failed to maintain minimal compliance with the Condition of Participation (COP) - Health Care Services. The facility failed to consistently provide adequate care, assessment and oversight to ensure provision of appropriate health care services to meet client medical needs.

Cross Reference W331. The facility failed to ensure appropriate nursing assessment, care and follow-up regarding client head banging and head injury.

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This finding resulted in a determination of Immediate Jeopardy (IJ) on 3/04/21 at 3:00 p.m. based on multiple incident reports of client head banging episodes, with inadequate nursing assessment or follow-up. Two sample clients had multiple incident reports regarding banging their heads on hard surfaces. Record review revealed staff typically did not contact nursing staff. Nursing notes related to the incidents could not be found, with the exception of two instances when a client went to the emergency room after showing signs of a possible concussion. The facility developed and implemented a plan of abatement to develop a head injury policy and retrain staff regarding head injury protocol, which included notifying nursing staff of head injuries. The IJ was removed on 3/10/21 at approximately 12:00 p.m.

Cross Reference W338: The facility failed to make referrals for medical evaluations in a timely manner.

Cross Reference W371: The facility failed to ensure clients were involved with medication administration.

W 331 NURSING SERVICES W 331
CFR(s): 483.460(c)

The facility must provide clients with nursing services in accordance with their needs.

This STANDARD is not met as evidenced by:
Based on interviews and record review, the facility failed to provide adequate nursing and health care training, assessment, and follow up related to client head injuries and client fractures.

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This affected 3 of 4 sample clients (Client #1, Client #12 and Client #17). Findings follow:

1. Record review on 3/03/21 revealed multiple Incident Reports for Client #1 and Client #12 regarding self-injurious behavior to their heads.

Record review revealed the following incident reports (IR) for Client #1 between 12/01/20 and 2/28/21:
a. On 12/29/20 Client #1 banged the back of her head on the door three times and then once on the floor. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed.

b. On 1/09/21 Client #1 hit her head on the floor three times before staff could put a pad between her head and the floor. Client #1 had redness on her forehead and complained of head pain. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed.

c. On 1/11/21 Client #1 began banging her head on the bathroom mirror. Staff blocked her head with their hand. Client #1 then began banging her head on the bathroom paper towel holder. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed.

d. On 1/23/21 Client #1 banged her head repeatedly on the floor and the wall. She also hit herself in the head. She began crying and said her head hurt. Staff called a facility nurse and transported Client #1 to the hospital emergency room. According to the IR, Client #1 was assessed at the emergency room and discharged with instructions to get rest and "needed to be monitored." The IR did not indicate how Client #1

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should be monitored. A nursing note was entered for this incident.

e. On 1/24/21 Staff escorted Client #1 to her room for behavioral issues, including aggression toward staff. Staff documented Client #1 laid on her bedroom floor and hit her head on the floor and the wall. Staff attempted to use pads to block Client #1's head from making contact with the hard surfaces, but she grabbed the pads and threw them at staff. Client #7 also punched herself in the head multiple times. The staff noted Client #7 banged her head three times "extremely hard" on the door and then laid on the ground grunting and not responding to staff questions. Client #7 seemed confused and disoriented. "She then fell asleep and staff tried waking her and she kept groaning at staff and not responding with works. She was asleep for 15-20 minutes and staff called nursing and they said to send her to ER." Staff transported Client #7 to the emergency room where she was diagnosed with a concussion.

f. On 1/27/21 Client #1 banged her head. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed.

g. On 2/21/21 Client #1 "self-harmed by hitting her head, she hit her head around 5 times on the front of her head." The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed.

h. On 2/24/21 a peer kicked Client #1 in the head. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed.

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i. On 2/26/21 Client #1 banged her head on the wall. The IR gave no indication a nurse was notified or a nursing/medical assessment was completed.

j. On 2/27/21 Client #1 punched herself in the face and was banging her head on the wall. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed.

Continued record review revealed the following nursing notes for Client #1 between 12/01/20 and 2/28/21 regarding head banging and/or head injury:

a. On 1/23/21 at 12:34 p.m. the nurse was notified by staff that Client #1 had been head banging. Client then indicated she felt dizzy and her head hurt. The nurse directed staff to take the client to the emergency room (ER) for a possible concussion. The nurse discussed the situation with the agency physician.

b. On 1/23/21 at 5:29 p.m. it was noted the nurse documented Client #1 returned to the facility from the (ER), with no new orders. The nurse noted staff told her the ER had checked Client #1's vital signs and did a quick neurological exam. The nurse documented she notified the agency physician. There was no further nursing follow-up note related to this incident.

c. On 1/24/21 at 12:35 p.m. the nurse was notified by staff that Client #1 had been head banging "pretty significantly". After she stopped, she appeared very tired and laid down and was making moaning and grunting noises. Client #1 told staff it felt like the room was spinning. The nurse notified the agency physician and they

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agreed to send the client to the ER. There was no additional nursing note regarding the outcome of the ER visit.

d. On 2/1/21 at 9:12 a.m. the nurse documented Client #1 was seen at a health clinic on 1/29/21 for follow-up for a concussion with loss of consciousness. Client #7 had improved. The nurse noted the clinic recommended, "continue to monitor symptoms", but provided no information on monitoring symptoms.

A physician's referral form revealed Client #1 saw a physician for concussion follow-up on 1/29/21. The diagnosis was listed as concussion with loss of consciousness (on 1/24/21). The referral form noted an improvement in overall condition and indicated Client #1 could return to normal activity. The referral form noted "continue to monitor symptoms".

Further record review revealed no type of facility follow-up related to the head banging incidents, such as neuro checks or monitoring for symptoms of concussion.

The Emergency Room document for 1/23/21 noted the diagnosis of injury to the head, with no follow-up recommendations.

The Emergency Room document for 1/24/21 noted the diagnosis of injury of head and concussion with loss of consciousness of 30 minutes or less. They recommended rest and no strenuous activity for Client #1. The recommendation to rest and avoid strenuous activity was not noted in the agency nursing notes.

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Client #1, 10 years old, had diagnoses including: mild intellectual disability, oppositional defiant disorder (ODD), autism spectrum disorder (ASD), and spider phobia.

b) Additional record review revealed the following IRs for Client #12 between 12/01/20 and 2/28/21:

a. On 12/27/20 Staff documented, "In an escalated state for about 30 minutes, (Client #12) banged the right and left sides of his head as well as his forehead on the wall approximately 20 times, making physical contact with the wall. At one point, it put a dent in the wall."

b. On 12/28/21 Client #12 was in his room "engaging in high intensity head-banging against walls, floors and the door." Staff attempted to use body positioning and pads but the client continued to engage in the behavior.

c. On 12/31/21 Client #12 became upset at a doctor appointment and banged his head on the wall. There was a visible red mark on his forehead, with no signs of concussion.

d. On 2/11/21 Client #12 was in an escalated state and banged his head with "high intensity" on the wall. He had a big red mark in the middle of his forehead.

e. On 2/20/21 Client #12 "continuously punched and banged his head against the walls and doors. It became excessive after being escorted to his room. His head banging resulted in 2 sores on the front/top of his head."

No nursing notes or nursing follow-up could be

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located in Client #12's record related to the incidents of head banging noted above.

When interviewed on 3/03/21 at 10:30 a.m. the HPM stated the facility did not have a Head Injury Protocol, but they had been working on one. Per the HPM, staff had been trained to call a facility nurse if a client's head banging resulted in signs of concussion. The facility provided a list with signs of concussion to staff during training, but the list was not posted. The facility also provided staff a form indicating when staff should contact the nurse, which was not posted. The facility trained staff on when to call the nurse and the signs of concussion every few months. The last training was completed October 2020. Not all staff attended the training, so the facility sent an email out with information regarding when to call nursing on 10/31/20. The facility provided the documentation for the training done in October 2020.

During a follow-up interview on 3/04/21 at 3:45 p.m. the HPM noted Client #1's school had requested the facility complete daily forms entitled "Student Concussion Symptom Checklist" when Client #1 was diagnosed as having a concussion on 1/24/21. The HPM acknowledged the forms were completed and sent to the school, but not regularly reviewed by facility nursing staff.

On 3/11/21 the HPM provided an agency packet entitled, "Caring for Clients at Tanager Place." The packet included signs and symptoms of concussion. According to the page with information regarding concussions, staff should notify nursing of any head injury with positive signs of a concussion. If no signs were present, staff should email nursing staff. The HPM

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provided samples of the emails on 3/11/21. The emails contained various information regarding what had occurred during the shift. As an example, an email dated 1/09/21 included, "(Client #1) - head", with no additional information. The email was sent to ICF/ID Cottage 3. The HPM said the nursing staff saw the emails sent to ICF/ID Cottage 3, but there was no indication when the nursing staff saw the email or of any follow up action/documentation.

This finding resulted in a determination of Immediate Jeopardy (IJ) on 3/04/21 at 3:00 p.m. based on multiple incident reports of client head banging episodes, with little to no nursing assessment or follow-up. Two sample clients had several incident reports regarding banging their heads on hard surfaces. The staff typically did not contact nursing staff and there were no nursing notes related to the incidents except in two instances when a client went to the emergency room after showing signs of a possible concussion. The facility developed and implemented a plan of abatement to develop a head injury policy and retrain staff regarding head injury protocol, which included notifying nursing staff of head injuries. The IJ was removed on 3/10/21 at approximately 12:00 p.m.

2. Observation at Terry Cottage on 3/02/21 from 7:03 a.m. to 8:04 a.m. revealed Client #17 did not wear an orthopedic boot for his broken foot. Client #17 ran around the cottage, aggressed toward Client #13, ate standing up, and pretended to fight with Client #12, while wearing nothing on his feet. At 7:25 a.m. Client #17 climbed the couch to the ledge and climbed over

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the ledge to the upper level, in his bare feet. The staff present did not prompt Client #17 to wear his boot during the approximately one hour observation. Client #14 prompted Client #17 to wear his boot at 7:37 a.m., but Client #17 did not put the boot on.

When interviewed on the afternoon of 3/02/21, Health and Practice Manager (HPM) confirmed Client #17 should wear his boot at all times, but he did have the right to refuse to wear it. During a follow-up interview on 3/04/21 at 10 a.m., the HPM provided three emails regarding Client #17's foot fracture and orthopedic boot. The HPM confirmed on the afternoon of 3/04/21 the three emails were the only documentation of staff training and there was no health care plan related to the broken foot.

Record review on 3/02/21 revealed an Incident Report (IR) for Client #17 on 2/01/21 at 4:45 p.m., noting Client #17 fell on the stairs at Terry Cottage. The IR indicated "displacement and fracture of his 5th metatarsal bone". On 2/02/21 at 9:25 a.m. the Registered Nurse followed up with an email, which noted "non weight bearing to the right foot." According to the email Client #17 "cannot participate in rec/gym activities that would require him to be up on his foot." A follow up physician's appointment on 2/05/21 indicated a new order from the doctor to "wear boot at all times; remove to bathe or shower". On 2/05/21 at 4:49 p.m. the Health Assistant (HA) sent a foot restriction email to Terry Cottage staff. According to the email, Client #17 was able to go without crutches, but he needed to wear his boot at all times (he could remove it to bathe or shower). On 3/02/21 at 5:11 p.m. the HA sent an updated email regarding Client #17's foot. The email

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W 331	Continued From page 33 indicated Client #17 needed to have his boot on when he woke up until he went to bed and if client #17 "is walking around the cottage without his boot, he needs to be prompted by staff to put his boot on." The email on 3/02/21 was sent to staff after the surveyor spoke to the HPM that afternoon regarding concerns that Client #17 did not wear his boot during observations on the morning of 3/02/21. Additional observation at Terry Cottage on 3/10/21 from 7:09 a.m. to 7:43 a.m. revealed Client #17 up and about in his bare feet. Client #17's orthopedic boot was on the floor in the common area of the second level of the cottage. Youth Service Worker (YSW) E, YSW C, and Shift Lead A walked by the boot throughout the observation. Client #17 walked around the cottage, ate breakfast standing up, and danced with staff. YSW E and Shift Lead A interacted with Client #17 throughout the time frame, but did not prompt the client to put on his boot. Client #17 independently put on his boot to leave for school at approximately 7:43 a.m.	W 331		
W 338	NURSING SERVICES CFR(s): 483.460(c)(3)(v) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on interviews and record review, the facility nursing staff failed to ensure timely referrals for care/services in accordance with	W 338		

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client needs. This affected 2 of 2 sample clients admitted in the past year (Client #1 and Client #17). Findings follow:

1. Record review on 3/03/20 and 3/04/20 revealed Client #1, admitted to the facility on 7/13/20. Her 30 Day Staffing was held on 8/24/20 (delayed due to a significant storm). According to the 30 Day Staffing, an Occupational Therapy (OT) evaluation would be discussed with the doctor during rounds and an eye exam may be delayed due to COVID. The staffing noted the last eye exam was done 9/11/19, prior to admission. A quarterly nursing assessment dated 10/15/20 noted the nursing staff assessed Client #1's vision as 20/40, which indicated a vision deficit. Client #1 did not have glasses. Current OT and optometry assessments could not be located in Client #1's chart.

When interviewed on 3/10/21 the Health and Practice Manager (HPM) reported Client #1 had an optometry appointment scheduled for 3/16/21. She said an eye exam had been scheduled in October 2020, but for some reason Client #1 didn't go to that appointment. The HPM didn't know why Client #1 didn't go to the appointment in October 2020 and could not provide an explanation as to why Client #1 had an appointment with the optometrist for an initial eye exam seven months after her admission date. The HPM also stated Client #1 had an OT evaluation scheduled for 3/22/21 and could not provide an explanation as to why the evaluation was being done seven months after admission.

2. Record review on 3/03/21 revealed Client #17, admitted to the facility on 5/22/20. According to his 30 Day Staffing, held 6/18/20, a referral for an

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W 338	Continued From page 35 OT evaluation had been requested. Additional record review revealed a Physician's Order for an OT evaluation dated 12/22/20. The OT evaluation was completed on 2/02/21, which was almost 8 1/2 months after admission.	W 338		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure participation in the medication administration process. This affected 2 of 4 non-sample clients observed during medication administration at Terry Cottage (Client #13 and Client #14). Finding follows: 1. Observations on 3/02/21 at 6:43 a.m. revealed the Medication Manager washed her hands and counted the double locked medication with Youth Service Worker C. The Medication Manager prompted Client #13 to come to the medication window. The Medication Manager scanned and popped the medication from the bubble packs into the medication cup. Client #13 took her medication from the Medication Manager. The Medication Manager reviewed the name or purpose of the medication with the client. The Medication Manager failed to encourage Client #13 to participate in any way in the medication pass.	W 371		

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W 371	Continued From page 36 2. Observations on 3/02/21 at 6:50 a.m. revealed the Medication Manager sanitized her hands and Client #14 came to the medication window. The Medication Manager scanned and popped the medication from the bubble packs into the medication cups. The Medication Manager prepared the Miralax in juice. Client #14 took her medication and Miralax from the Medication Manager. The Medication Manager did not review the name or purpose of the medication with the client. The Medication Manager failed to encourage Client #14 to participate in any way in the medication pass. When interviewed on 3/16/21 at 8:45 a.m. the Health and Practice Manager confirmed the clients should be involved in their medication administration.	W 371		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to conduct third shift fire drills at varied times. This potentially affected 9 of 9 residents living at the Sinclair Cottage (Client #1, Client #2, Client #3, Client #4, Client #5, Client #6, Client #7, Client #8, and Client #9). Finding follows: Record review on 3/01/21 for Sinclair Cottage revealed third shift fire drills in the past year completed on the following dates and times:	W 441		

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12/10/20 at 6:45 a.m., 9/30/20 at 6:40 a.m., and 6/25/20 at 7:30 a.m. All fire drills were held within a 50 minute time frame, between 6:40 a.m. and 7:30 a.m.

When interviewed on 3/01/21 at 11:00 a.m. the ICF/ID Program Manager (PM), stated the 7:30 a.m. fire drill could be considered to be on the third shift because the third shift staff worked until 8:30 a.m. However, the PM acknowledged first shift staff came into work at 6:30 a.m. The PM confirmed the times the fire drills were held, which were not varied.

During a follow up interview 3/03/21 at 3:45 p.m. the PM stated there was no written information regarding shift times in relation to fire drills.

W 460 | W 460

FOOD AND NUTRITION SERVICES
CFR(s): 483.480(a)(1)

Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

This STANDARD is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to consistently provide food items listed on the menu. This affected 8 of 8 clients residing at the Terry Cottage (Client #10, Client #11, Client #12, Client #13, Client #14, Client #15, Client #16 and Client #17.) Finding follows:

Observation at Terry Cottage on 3/10/21 at 7:01 a.m. revealed the breakfast items at the staff desk/counter area, including cereal, bread and milk. Client #11 asked Youth Service Worker

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W 460	Continued From page 38 (YSW) E for a glass of juice. YSW E told Client #11 he could have juice when it came with breakfast on the weekend. YSW E further explained to Client #11 he did not need juice as he did not take Miralax. When interviewed on 3/10/21 at 7:25 a.m. YSW D explained the clients generally ate toast and cereal Monday through Friday. YSW D said the clients were provided a hot breakfast on the weekends. When asked about fruit, YSW D showed the surveyor an empty pink bowl in a cupboard, which was supposed to be the fruit bowl. YSW D said she needed to order more fruit. She confirmed that Monday through Friday juice was offered only to clients who had medication that needed to be mixed with a liquid, such as Miralax. Record review on 3/11/21 of the menu for the week of 3/07/21 to 3/13/21, revealed the daily breakfast menus for the entire week included 1/2 cup fruit and 1/2 cup fruit juice with breakfast. When interviewed on 3/16/21 at 8:45 a.m., the Health and Practice Manager confirmed the residents should have been offered fruit and fruit juice, per the menu.	W 460		
W 461	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(2) A qualified dietitian must be employed either full-time, part-time, or on a consultant basis at the facility's discretion. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W 461		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G139	A. BUILDING ______ B. WING ______	03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANAGER PLACE	2309 C STREET SW CEDAR RAPIDS, IA 52404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 461	Continued From page 39	W 461		

failed to consistently employ a qualified dietician. This affected 2 of 2 sample clients admitted in the past year (Client #1 and Client #17) and potentially affected 17 of 17 clients residing at the facility (Client #1 - Client #17). Finding follows:

Record review on 3/03/20 and 3/04/20 revealed Client #1 and Client #17 were admitted to the facility in the past year. Initial dietary assessments were completed in December 2020, several months after their admission. (See W 217)

When interviewed on 3/03/21 at 3:00 p.m. the Health and Practice Manager (HPM) reported the facility's contract dietician resigned her position in the spring of 2020 and the facility did not hire another contract dietician until December 2020. As a result, no dietary assessments or services were completed during that time. The HPM provided emails which revealed the previous contract dietician notified the agency on 3/02/20 she would be unable to do in-patient consultations at the facility as of 4/01/20. In a follow-up email dated 4/07/20, the dietician indicated she would continue to provide services through the month of April in order to give the agency time to find a replacement. There were additional emails with a prospective dietician, who ultimately declined the position in July 2020. The HPM provided internal emails in October 2020 between agency management staff noting a dietician was still needed, but the agency provided no additional information regarding actively searching for a dietician.

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Tanager Place CMS-2567

W000 – Initial Comments.

No Plan of correction required.

W124: Protection of Clients Rights – The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent [if the client is a minor], or legal guardian, of the clients medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

Failed to obtain written informed consent for behavior modifying medications, which included updated medications and potential side effects.

- Modifications were made to the HRC Informed consent to include notification of side effects and risks. This includes possible side effects, other complications from treatments [medical and drug therapy], unintended consequences of treatment, other behavioral or psychological ramifications arising from treatment.
- HRC consent has been modified to ensure that specific medications are indicated as well as the drug ranges.
- Nursing Services initiates contact with parent/legal guardian [if a minor] to obtain informed consent for new behavior modifying medications. Drug information sheet is provided to parent/guardian [if a minor] to outline benefits, uses, side effects, and possible interactions.
- Library of drug information has been created and data sheets are to be provided in addition to the verbal education provided by Nursing Services.
- Once parental/guardian consent has been obtained, documentation of date and time of verbal consent will be collected on the Authorization for Medication. Follow-up for written consent will begin immediately.
- QIDP will follow-up with Human Rights Committee [HRC] to obtain verbal and written consent. Drug information sheet is provided to HRC [if a minor] to outline benefits, uses, side effects, and possible interactions.
- Procedures have been implemented to ensure written consent is returned
- No behavior modifying medication will be started without written consent from parent/legal guardian [if a minor] and member of HRC. In the event of an emergency [as determined by the treating physician], the facility may begin

behavior modifying medications once verbal consent is obtained. This verbal consent will be authenticated in writing as soon as possible [not to exceed 30 days].

Methods to monitor compliance: Nursing Services will enter all medications on the HRC informed consent and will forward completed HRC consent form to QIDP. QIDP will verify consent contains verbal consent. Once written consent is obtained from HRC committee, this will be forwarded to Inpatient Administrative assistant for filing. Health checklist has been created to help support this process. QIDP will monitor consent dates [obtained and expired] via the HRC Behavior Modification informed consent.

Person[s] responsible: Nursing Services, and QIDP's [Maurice Woods and Avary Brinker]

Date of correction: Implemented fully 05/17/2021

W153: Staff Treatment of Clients: all allegations of mistreatment, neglect, or abuse as well injuries of unknown source are reported immediately to Administrator or to other officials.

Facility failed to report allegations of abuse in a timely manner.

- All allegations of abuse are to be entered into the Electronic Health Record to improve documentation process and review of allegations.
- Customized report created to monitor reporting process and ongoing follow-up needs.
- Self-report checklist for allegations reviewed in Inpatient team meeting and additional training to direct care staff on who to notify when an allegation is made.
- Incident tracker created in excel to monitor allegations of abuse and ensure reported within 24 hours of allegation being made or the next business day based on policy.
- Facility has continued to show compliance with this since October 2020 when above measure were put into place.

- Health and Practice Manager and VP of Operations will continue to monitor incident tracker each business day to ensure remain in compliance.

  Methods to monitor compliance: Self check list developed to monitor compliance with reporting procedures. This checklist is to be completed for each allegation. QIDPs will encourage open reporting and periodically check with each client around safety. Incident tracker created to monitor date of allegation being made and reporting of allegations to appropriate officials per State Law.

  Person[s] Responsible: Health and Practice Manager [Tiffany Bunting] monitors to ensure staff are reporting all allegations of abuse.

  Date of correction: Implemented fully October 2020

W159: QIDP – Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.

Failed to ensure a Qualified Intellectual Disability Professional [QIDP] monitored individual program plans, reviewed incident reports, and incorporated professional recommendations into client programs.

- Upon QIDP extended absence [greater than 2 weeks], Clinical manager or designee will begin review of Incident Reports, observations of IPP in the milieu, implementation of interventions, and analysis of data.
- Collaborative supervision template created to ensure that QIDP is evaluating clients program and making appropriate modifications. This is to be done weekly with Clinical Manager or designee.
- Nursing Services will review IPP's at minimum monthly to ensure that recommendations from specialists are incorporated in a timely manner.

Methods to monitor compliance: Clinical Manager, or designee and QIDP[s] will attend collaborative supervision to ensure that client's programs are being evaluated and appropriate modifications are being made. Nursing Services will begin review of IPP's at minimum monthly to ensure that recommendations from specialists are incorporated.

Person[s] responsible: Clinical Manager, or designee and QIDPs [Maurice Woods and Avary Brinker]

Date of correction: Fully implemented 05/17/2021

W191: Staff Training Program: For employees who work with clients, training must focus on skills and competencies directed towards clients behavioral needs.

Facility failed to ensure staff competently implemented interventions to address client behavioral needs.

- Observation template created with QIDPs to observe implementation of interventions identified in each IPP, at minimum 1 per week. Any identified issues with escorts is to be lifted up to the Health and Practice Manager for further review.
- Training on escorts had been developed to review proper form of escort and ensure competency development for existing staff and new hires.
- This training component added to the onboarding checklist with procedures implemented to observe within first 30 days, at 2 months, 4 months, and 6 months post onboarding.

Methods to monitor compliance: QIDPs will assess during observations and lift up any concerns related to behavior management. LP will monitor interventions and provide instruction and/or redirection around escorts vs. STPs. Health and Practice Manager will continue to monitor video footage of incidents [as applicable to policy] and will lift up concerns related to improper escorts.

Person[s] responsible: QIDPs, LPs, and Health and Practice Manager.

Date of correction: Fully implemented by 05/17/021

W193: Training Program: Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the appropriate behavior of clients.

Facility failed to consistently demonstrate the skills and competencies necessary to manage inappropriate client behavior.

- Observation template created with QIDPs to observe implementation of interventions identified in each IPP, at minimum 1 per week. Any identified issues with escorts is to be lifted up to the Health and Practice Manager for further review.

- Training on escorts had been developed to review proper form of escort and ensure competency development for existing staff and new hires.
- This training component added to the onboarding checklist with procedures implemented to observe within first 30 days, at 2 months, 4 months, and 6 months post onboarding.

Methods to monitor compliance: QIDPs will assess during observations and lift up any concerns related to behavior management. LP will monitor interventions and provide instruction and/or redirection around escorts vs. STPs. Health and Practice Manager will continue to monitor video footage of incidents [as applicable to policy] and will lift up concerns related to improper escorts.

Person[s] responsible: QIDPs, LPs, and Health and Practice Manager.

Date of correction: Fully implemented by 05/17/021

W216: Individual program plan – The comprehensive functional assessment must include physical development and health.

Facility failed to obtain physicals in a timely manner.

- Admissions and Nursing Services will work with family to ensure physical is completed prior to admission.
- If unable to complete prior to admission, Nursing Services will schedule with EIHC within 7 days of admit.
- If EICH is unable to see client within 7 days, our treating psychiatrist will do full head to toe physical within 7 days.

Methods to monitor compliance: Nursing Services will monitor last physical date and upcoming due dates to ensure done in timeframes outlined.

Person[s] responsible: Nursing Services

Date of correction: Fully implemented 05/17/2021

W217: Individual program plan – The comprehensive functional assessment must include nutritional status.

Facility failed to assess nutritional/dietary needs in a timely manner.

- Dietary/nutritional needs to be assessed within 30 days of admission.
- Comprehensive functional assessment revised to include section on dietary/nutritional status.
- If Dietician is able to see client within first 30 days, QIDP will have dietician complete the dietary section of the CFA.
- If unable to be seen by contract dietician within that timeframe, Nursing Services or QIDP will complete full dietary/nutritional section of the CFA.

Methods to monitor compliance: Nursing Services will notify Dietician of all new admits. If unable to be seen within 30 days, Nursing Services will ensure CFA gets completed by a member of Nursing Services or QIDP.

Person[s] responsible: Nursing Services and QIDPs

Date of correction: Fully Implemented by 05/17/2021

W249: Program Implementation – as soon as the interdisciplinary team [IDT] 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.

Failed to ensure consistent implementation of the individual program plan [IPP] for behavior management and/or adaptive equipment for behavior.

- Observation template created in Electronic Health record for QIDPs to observe implementation of interventions identified in each IPP, at minimum once per week.
- QIDP will assess staff's ability to independently run each intervention, offer prompts as needed, or model use of intervention to ensure consistent implementation of each IPP.
- QIDPS to be trained on new template Tuesday May 6th, with utilization to begin week of May 10th.

Methods to monitor compliance: Clinical manager, or designee, will weekly review completion of observation template and client needs to ensure consistent implementation of each IPP,

Person[s] responsible: Clinical manager, or designee

Date of correction: 05/10/2021

W316 – Drug Usage - Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.

Failed to attempt to decrease behavior modifying medication or justification for lack of medication decrease.

- Medication reduction procedures created to ensure review of behavior modifying medication at minimum bi-annually. This will to occur simultaneously with the bi-annual review.
- Active medication list is to be reviewed with attending physician and IDT. Should a medication reduction be contraindicated it will be clearly identified within the HRC consent and letter obtained from Treating Psychiatrist and QIDP regarding reasons why medication would be contraindicated at this time – date reviewed.
- QIDPs will update HRC consent and ensure letter is obtained and placed on client's record.

Methods to monitor compliance: Clinical Manager, or designee, will review master tracker to ensure medication reduction is occurring annually. Clinical manager will review bi-annual reports and HRC consents during supervision as applicable when due/coming due.

Person[s] responsible: Clinical Manager, or designee, and QIDPs.

Date of correction: Implemented fully by 05/17/2021

W318 – Health care services – The facility must ensure that specific health care services requirements are met.

Failed to maintain minimal compliance with the Condition of Participation [COP] – health care services. The facility failed to consistently provide adequate care, assessment, and oversight to ensure provision of appropriate health care services to meet client medical needs.

Immediate actions:

- Nursing staff has placed signage on med room doors regarding when to notify nursing.
- Signage includes signs and symptoms of concussions.
- Nursing staff is to provide training 3/04/2021 with staff on shift currently around when to notify nursing as well as signs and symptoms of concussions.
- Email sent to all of Inpatient staff regarding training material. Staff are to review with a member of leadership team prior to the start of their next shift.
- IPPs for Client 1 and 12 reviewed. Client 1 will include a matrix for how to address her hand banging in consideration of her past trauma.
- The administrative review of accidents/injuries involving head injury will include justifications regarding recommendations and/or further medical needs.
- A protocol for head banging is to be finalized and sent out to all staff by end of day 3/05/2021.
  - Email sent by end of day 3/05/2021 with protocol outlined.
  - All staff are to review and acknowledge receipt of protocol prior to start of shift by end of day 3/07/2021
  - Expectations outlined in the protocol for any head-banging that results in contact with a hard surface such as a floor or wall include:
    - Immediately call or have someone call nursing [nursing office or on call nursing phone 319-350-5685]
    - In order to ensure that facility is able to provide Nursing Services in accordance with client's needs, nursing staff will be available through a combination of face to face assessment [telehealth or in office] and on-call consultation. Should a client require 24/7 nursing care interdisciplinary team will staff during weekly case staffing's and identify whether higher-level of care may be warranted.
    - If RN is on campus and available [i.e. not attending to more urgent client needs], nurse will immediately report to clients location to observe clients injury and health status.
    - If RN is not on campus or immediately available [i.e. attending to more urgent client needs], health assistant, LVN, or LPN under the direction of RN can complete concussion assessment and report findings to medical director.
    - If a member of our nursing staff is unable to conduct a full assessment within 30 minutes, staff are to take client to the ER for nursing assessment.
    - Upon return from ER, if a client is diagnosed with a head injury nursing staff will follow head injury protocol.
    - ** Please note, per signage if staff feel that a 911 call is warranted they have been instructed to contact 911 before calling Nursing Services.
- Inpatient Manager[s] in conjunction with Health and Practice Manager will monitor to assure that systems are effectively implemented, and the facility

takes immediate actions to notify nursing when head injury, or suspected head injury has occurred, so that the nurse is able to respond timely to all medical concerns, conduct appropriate assessments, provide appropriate interventions, and monitor progress following head injury.

Methods to monitor compliance: Inpatient Manager[s] will monitor for compliance and work closely with Health and Practice Manager, Executive team and IP Governing Body around ongoing nursing policy development and periodic reviews with staff.

Person[s] responsible: Tim Feldmann, Inpatient Operations Manager and Tiffany Bunting, Health and Practice Manager

Date of correction: Immediately upon receipt.

W331 – Nursing Services: the facility must provide clients with Nursing Services in accordance with their needs.

Facility failed to provide adequate nursing and health care training, assessment, and follow-up related to client head injuries and client fractures.

Immediate actions:

- Nursing staff has placed signage on med room doors regarding when to notify nursing.
- Signage includes signs and symptoms of concussions.
- Nursing staff is to provide training 3/04/2021 with staff on shift currently around when to notify nursing as well as signs and symptoms of concussions.
- Email sent to all of Inpatient staff regarding training material. Staff are to review with a member of leadership team prior to the start of their next shift.
- IPPs for Client 1 and 12 reviewed. Client 1 will include a matrix for how to address her hand banging in consideration of her past trauma.
- The administrative review of accidents/injuries involving head injury will include justifications regarding recommendations and/or further medical needs.
- A protocol for head banging is to be finalized and sent out to all staff by end of day 3/05/2021.
  - Email sent by end of day 3/05/2021 with protocol outlined.
  - All staff are to review and acknowledge receipt of protocol prior to start of shift by end of day 3/07/2021
  - Expectations outlined in the protocol for any head-banging that results in contact with a hard surface such as a floor or wall include:

- Immediately call or have someone call nursing [nursing office or on call nursing phone 319-350-5685]
- In order to ensure that facility is able to provide Nursing Services in accordance with client's needs, nursing staff will be available through a combination of face to face assessment [telehealth or in office] and on-call consultation. Should a client require 24/7 nursing care interdisciplinary team will staff during weekly case staffing's and identify whether higher-level of care may be warranted.
- If RN is on campus and available [i.e. not attending to more urgent client needs], nurse will immediately report to clients location to observe clients injury and health status.
- If RN is not on campus or immediately available [i.e. attending to more urgent client needs], health assistant, LVN, or LPN under the direction of RN can complete concussion assessment and report findings to medical director.
- If a member of our nursing staff is unable to conduct a full assessment within 30 minutes, staff are to take client to the ER for nursing assessment.
- Upon return from ER, if a client is diagnosed with a head injury nursing staff will follow head injury protocol.
- ** Please note, per signage if staff feel that a 911 call is warranted they have been instructed to contact 911 before calling Nursing Services.

➢ Inpatient Manager[s] in conjunction with Health and Practice Manager will monitor to assure that systems are effectively implemented, and the facility takes immediate actions to notify nursing when head injury, or suspected head injury has occurred, so that the nurse is able to respond timely to all medical concerns, conduct appropriate assessments, provide appropriate interventions, and monitor progress following head injury.

Additional actions taken:

➢ Nursing staff has placed signage on med room doors regarding when to notify nursing.
➢ Further education provided on identifying possible fractures.
➢ Upon diagnosis of fracture, Nursing Staff are to assess as needed and provide instruction for fracture care.
➢ QIDP's are to implement proper fracture care into IPP [i.e. prompts for when to use boot or crutches if applicable]
➢ Nursing Services and QIDPs will conduct observations, at minimum monthly, to ensure that staff are properly providing fracture care.
➢ Inpatient Manager[s] in conjunction with Health and Practice Manager will monitor to assure that systems are effectively implemented, and the facility takes immediate actions to notify nursing when fracture, or suspected fracture has occurred, so that the nurse is able to respond timely to all

medical concerns, conduct appropriate assessments, provide appropriate interventions, and monitor progress following fracture.

Methods to monitor compliance: Inpatient Manager[s] will monitor for compliance and work closely with Health and Practice Manager, Executive team and IP Governing Body around ongoing nursing policy development and periodic reviews with staff.

Person[s] responsible: Tim Feldmann, Inpatient Operations Manager and Tiffany Bunting, Health and Practice Manager

Date of correction: Immediately upon receipt.

W338 – Nursing Services: Nursing Services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action [including referral to a physician to address client health problems].

Facility failed to ensure timely referrals for care/services in accordance with client needs.

- Master tracker modified to include dates for referrals for care/services in accordance with clients identified needs from CFA.
- Identifies if a referral is needed, dates of appointments, and any follow-up needed.
- To be reviewed within 30 days of admit [per timeframe of CFA completion]
- Nursing Services will provide all recommendations and needed follow-up to QIDPs upon conclusion of appointment.
- Master Tracker will be updated by QIDP with any recommendations and ongoing needs.

Methods to monitor compliance: Upcoming appointments to be reviewed weekly at Nursing Services meeting. Master Tracker to be reviewed in weekly supervision with QIDPs.

Person[s] responsible: Tiffany Bunting, Health and Practice Manager

Date of correction: Fully implemented by 05/17/2021

W371 – Drug Administration: The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

Failed to ensure participation in the medication observation process.

- Medication Managers provided additional instruction around ways to encourage client participation in the medication pass.
- QIDP is to develop IPP for each client regarding medication pass and how clients are to participate.
- Fidelity checklist modified to include observation of med-pass. Each Medication Manager is to be observed at minimum monthly to ensure they are encouraging client participation in the medication pass.

  Methods to monitor compliance: Nursing Services, or designee, will monitor each active medication manager at minimum monthly.

  Person[s] responsible: Nursing Services [Tiffany Bunting, Health and Practice Manager, RN's, or LPN]

  Date of correction: Fully implemented by 05/17/2021

W441 – Evacuation Drills: The facility must hold evacuation drills under varied conditions.

Failed to conduct third shift drills at varied times.

- Inpatient Operations Manager will look at schedule of drills to occur on a quarterly basis, ensuring each shift occurs at varied times.
- 1st shift drills will occur at varied times between the hours of 6:30am and 2:30 pm.
- 2nd shift drills will occur at varied times between the hours of 2:30 pm and 10:30 pm
- 3rd shift drills will occur at varied times between the hours of 10:30 pm and 6:30 am.
- Quality & Risk Management Coordinator will review fire drill sheets monthly to ensure that Cottage staff are holding drills per varied schedule.

  Methods to monitor compliance: Inpatient Operations Manager will schedule at varied times. Quality and Risk Management Coordinator will review fire drill sheets to ensure held at varied times.

  Person[s] responsible: Inpatient Operations Manager and Quality and Risk Management Coordinator

Date of correction: Fully implemented by 05/17/2021

W460 – Food and Nutrition Services: Each client must receive a nourishing well-balanced diet including modified and specially-prescribed diets.

Facility failed to consistently provide food items listed on the menu.

- Additional instruction provided to staff on importance of offering food items listed on the menu.
- Meal count checklist will be completed to identify what was offered each meal.
- Supervisors will monitor meal count checklist to ensure that staff are offering each meal.

Methods to monitor compliance: Cottage supervisors will monitor completion of meal count checklist to ensure that each menu item has been offered to clients each meal.

Person[s] responsible: Cottage Supervisors

Date of correction: Fully implemented 05/17/2021

W461: Food and nutrition services: A qualified dietician must be employed either full-time, part-time, or on a consultant basis as the facility's discretion.

Facility failed to consistently employ a qualified dietician.

- Dietician is to remain employed or on contract to provide dietary evaluations.
- Should our current dietician provide notice, the facility will take the following measures to ensure we are able to locate a replacement timely:
  - Post for position online
  - Complete reverse look-up for part-time or contract dietician.
  - Connect with local providers regarding contract/consultation options.
  - Detailed notes will be kept regarding efforts to obtain replacement.

Methods to monitor compliance: HR will review employment status to ensure dietician remains active. Nursing Services will monitor to ensure that clients are being seen by dietician per identified needs.

Person[s] responsible: VP of Operations, Jess Kelly and Human Resources

Date of correction: October 2020

OST 2567

W331 – Nursing Services: the facility must provide clients with Nursing Services in accordance with their needs.

Facility failed to provide adequate nursing and health care training, assessment, and follow-up related to client head injuries and client fractures.

Immediate actions:

- Nursing staff has placed signage on med room doors regarding when to notify nursing.
- Signage includes signs and symptoms of concussions.
- Nursing staff is to provide training 3/04/2021 with staff on shift currently around when to notify nursing as well as signs and symptoms of concussions.
- Email sent to all of Inpatient staff regarding training material. Staff are to review with a member of leadership team prior to the start of their next shift.
- IPPs for Client 1 and 12 reviewed. Client 1 will include a matrix for how to address her hand banging in consideration of her past trauma.
- The administrative review of accidents/injuries involving head injury will include justifications regarding recommendations and/or further medical needs.
- A protocol for head banging is to be finalized and sent out to all staff by end of day 3/05/2021.
  - Email sent by end of day 3/05/2021 with protocol outlined.
  - All staff are to review and acknowledge receipt of protocol prior to start of shift by end of day 3/07/2021
  - Expectations outlined in the protocol for any head-banging that results in contact with a hard surface such as a floor or wall include:
    - Immediately call or have someone call nursing [nursing office or on call nursing phone 319-350-5685]
    - In order to ensure that facility is able to provide Nursing Services in accordance with client's needs, nursing staff will be available through a combination of face to face assessment [telehealth or in office] and on-call consultation. Should a client require 24/7 nursing care interdisciplinary team will staff during weekly case staffing's and identify whether higher-level of care may be warranted.
    - If RN is on campus and available [i.e. not attending to more urgent client needs], nurse will immediately report to clients location to observe clients injury and health status.

- If RN is not on campus or immediately available [i.e. attending to more urgent client needs], health assistant, LVN, or LPN under the direction of RN can complete concussion assessment and report findings to medical director.
- If a member of our nursing staff is unable to conduct a full assessment within 30 minutes, staff are to take client to the ER for nursing assessment.
- Upon return from ER, if a client is diagnosed with a head injury nursing staff will follow head injury protocol.
- ** Please note, per signage if staff feel that a 911 call is warranted they have been instructed to contact 911 before calling Nursing Services.

➢ Inpatient Manager[s] in conjunction with Health and Practice Manager will monitor to assure that systems are effectively implemented, and the facility takes immediate actions to notify nursing when head injury, or suspected head injury has occurred, so that the nurse is able to respond timely to all medical concerns, conduct appropriate assessments, provide appropriate interventions, and monitor progress following head injury.

Additional actions taken:

➢ Nursing staff has placed signage on med room doors regarding when to notify nursing.
➢ Further education provided on identifying possible fractures.
➢ Upon diagnosis of fracture, Nursing Staff are to assess as needed and provide instruction for fracture care.
➢ QIDP's are to implement proper fracture care into IPP [i.e. prompts for when to use boot or crutches if applicable]
➢ Nursing Services and QIDPs will conduct observations, at minimum monthly, to ensure that staff are properly providing fracture care.
➢ Inpatient Manager[s] in conjunction with Health and Practice Manager will monitor to assure that systems are effectively implemented, and the facility takes immediate actions to notify nursing when fracture, or suspected fracture has occurred, so that the nurse is able to respond timely to all medical concerns, conduct appropriate assessments, provide appropriate interventions, and monitor progress following fracture.

Methods to monitor compliance: Inpatient Manager[s] will monitor for compliance and work closely with Health and Practice Manager, Executive team and IP Governing Body around ongoing nursing policy development and periodic reviews with staff.

Person[s] responsible: Tim Feldmann, Inpatient Operations Manager and Tiffany Bunting, Health and Practice Manager

Date of correction: Immediately upon receipt.

W153: Staff Treatment of Clients: all allegations of mistreatment, neglect, or abuse as well injuries of unknown source are reported immediately to Administrator or to other officials.

Facility failed to report allegations of abuse in a timely manner.

- All allegations of abuse are to be entered into the Electronic Health Record to improve documentation process and review of allegations.
- Customized report created to monitor reporting process and ongoing follow-up needs.
- Self-report checklist for allegations reviewed in Inpatient team meeting and additional training to direct care staff on who to notify when an allegation is made.
- Incident tracker created in excel to monitor allegations of abuse and ensure reported within 24 hours of allegation being made or the next business day based on policy.
- Facility has continued to show compliance with this since October 2020 when above measure were put into place.
- Health and Practice Manager and VP of Operations will continue to monitor incident tracker each business day to ensure remain in compliance.

Methods to monitor compliance: Self check list developed to monitor compliance with reporting procedures. This checklist is to be completed for each allegation. QIDPs will encourage open reporting and periodically check with each client around safety. Incident tracker created to monitor date of allegation being made and reporting of allegations to appropriate officials per State Law.

Person[s] Responsible: Health and Practice Manager [Tiffany Bunting] monitors to ensure staff are reporting all allegations of abuse.

Date of correction: Implemented fully October 2020