DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	522690	A. BUILDING: ______ B. WING ______	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NEUROREHAB - GLEN OAKS	2033 GLEN OAKS RIDGE CORALVILLE, IA 52241

✓12/22/20

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T 000	Initial Comments There were no deficiencies cited during the onsite infection control survey. The following deficiencies were cited during the investigation of Compliant 93361-C.	T 000		
T1220	481-63.14(3)e Records 63.14(3) Incident record. e. An incident report shall be completed for every accident, incident or unusual occurrence within the facility or on the premises that affects a resident, visitor, or employee. (II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report incidents and unusual occurrences for 3 of 4 current residents (Residents #1, #2, #3) and 1 of 2 former residents (Resident C-1) reviewed. Findings follow: On 9/22/20 review of Daily Logs revealed on 1/1/17 Resident #1 passed notes back and forth with Resident C-1 in a Word Jumble book. Staff looked at the notes and realized Resident #1 had propositioned Resident C-1 for sex. A short time later the staff person found Resident #1 kissing Resident C-1. The staff member also heard Resident #1 ask Resident C-1 to come to his room that night. On 1/5/2017, Resident #1 snuck into Resident C-1's room in the early morning hours and got into her bed. Resident #1 came out of his room at 1:30 AM on 1/6/17 and was found climbing into Resident C-1's bed at 1:45 AM. On 1/14/17, staff found Resident #1 in Resident C-1's bed hiding beneath the blankets. Staff found Resident #1 in Resident C-1's bed	T1220	481-63.14(3)e Records-Incident record: Community NeuroRehab's (CNR) electronic health record includes a detailed incident reporting menu that includes an "other" category. At the time of the exit interview for the survey, CNR had implemented the following to address this deficiency: 1) The menu of incident types was expanded to included "unusual occurrences" as the "other" category was not appropriately capturing this need. 2) CNR's Clinical Director sent a company wide informational email to notify staff about the addition and scope of "unusual occorances" and training was scheduled, and subsequently provided, at the next scheduled staff meetings. 3) Incident report reveiws are a part of CNR's 3x weekly Quality Review Meetings. CNR's Clinical Director added "unusual occurrences" to the standing agenda as part of the incident report review agenda item. (Continued on sheet 2 of 8)	9/30/20 9/30/20 9/30/20

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

✓ 12/16/20

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T1220	Continued From page 1	T1220	(Continued from sheet 1 of 8)	
	with the door closed on 2/1/17. On 2/28/17, Resident #1 asked Resident C-1 to touch his genitals. Resident #1 entered Resident C-1's room on 3/10/17 when she was asleep. On 3/20/17, Resident #1 was witnessed kissing Resident C-1 with his hands on her breasts and vagina. Resident #1 was found in Resident C-1's bed at 5:00 AM on 4/18/17. Resident #1 was seen smoking what appeared to be marijuana at the facility with another resident on 2/5/18. Resident #1 confirmed to staff he was smoking marijuana on 2/6/18. It was documented on 3/24/18 staff heard a doorbell ring which was attached to Resident #1's door, but did not notice him leave the house as the front/back door alarms were not heard by the staff members. Upon his return, staff expressed to Resident #1 they were aware he had gone to WalMart. Resident #1 had a safety plan which noted he was to access the community with staff support due to his impulse control deficits. On 4/23/18, Resident #1 went downstairs and laid on the bed of Resident C-1 who was napping. Resident #1 was found in Resident C-1's room on 5/12/18 when she was sleeping. When staff approached Resident #1, he pulled up his pants. He was asked to leave the room. On 6/7/20, Resident #1 left the house at 5:15 PM without staff. Staff located Resident #1 within a few blocks and followed him as he walked to WalMart. There were no incident reports written for any of these occurrences.		4) The Quality Assurance Documentation Reviewer will work ongoing with the Clinical Coordinator to ensure that incident reports are completed for "unusual occurrences".	9/30/20
			In addition to the above noted immediate actions taken the following will take place:	
			5) CNR's CEO will revise compliance policy "C10 - Notification and Reporting of at Risk Behaviors or Major Injuries" to "C10 - Incident Reporting and Notification/Reporting of At Risk Behaviors and Major Injuries."	12/31/20
			6) CNR's Clinical Director will provide training at staff meetings on the revised C10 policy. Training on policy C10 will also take place during the new employee orientation process.	1/15/21
	A review of Daily Logs for Resident C-1 revealed on 1/5/17 she appeared to be asleep when staff arrived for the shift at 7:00 AM. Staff intervened when they heard Resident 1 enter her bedroom around 7:30 AM. He was found lying next to her in bed. On 1/14/17 Resident C-1 exited her room at 5:30 AM to use the bathroom. At that time,			

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T1220	Continued From page 2 staff noticed Resident #1 was in her room. She stated Resident #1 entered her room immediately prior to her exiting to use the restroom. No incident reports were written documenting these as unusual occurrences. A review of a Daily Log for Resident #2 dated 9/13/20 indicated he was seen masturbating with Resident #3 around 9:00 PM on the outside patio twice. There was no written incident reports for either resident.. The Chief Executive Officer, Clinical Director and Clinical Coordinator confirmed these findings on 9/30/20 at 3:30 PM. The Chief Executive Officer reported a company-wide email had been sent out to ensure incident reports were being written to address unusual occurrences. The facility was also working on developing a new policy to ensure incident reports would be written as needed.	T1220		
T1645	481-63.19(3)c Orientation and Service Plan 63.19(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident and the resident's interdisciplinary team, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to	T1645	481-63.19(3)c Orientation and Service Plan: This survey included a retrospective lookback of several years and CNR had previously (since the identified events took place) updated its process of modifying service plans when a change of condition takes place. This process was changed in October of 2018. The updated process required the Clinical Coordinator to convene the treatment team when a resident experiences a change of condition. (Continued on sheet 4 of 8)	

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T1645	Continued From page 3 service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure service plans included specific services to achieve goals for 1 of 4 current residents reviewed (Resident #1). Findings follow: A review of Multidisciplinary Progress Notes, Daily Notes and Personal Intervention Plans (PIP) revealed the following timeline of events regarding Resident #1 and Resident C-2: On 1/1/17 Resident #1 passed notes back and forth with Resident C-1 and propositioned her for sex. The staff member later noted Resident #1 was seen kissing Resident C-1. The staff member made his presence known and they stopped. Later that night, Resident #1 talked to Resident C-1 about coming to his. On 1/2/17 a staff member heard Resident #1 tell Resident C-1 he would sneak into her room at 4:00 AM. Staff encouraged Resident #1 to maintain the friendship but not to pursue the romantic relationship. Staff also discussed nonverbal cues and processed with Resident #1 how Resident C-1 was responding to him. Staff identified and discussed concerns Resident C-1 had brought to them, expressing she was uncomfortable with his advances. Resident #1 snuck into Resident C-1's bed early in the morning on 1/5/17 when she was trying to sleep. Staff emphasized his actions were not appropriate and it was never okay to sneak into someone's bed uninvited. Staff encouraged him	T1645	(Continued from sheet 3 of 8) The treatment team modifies the service plan to meet the needs of the resident in accordance with the change of condition. Any change is conveyed to all individuals inside and outside of the facility who work with the resident experiencing the change, within five working days of the change. In addition and moving forward: 1) The IPP documentation form (IPP Summary Template) has been updated since the survey to specifically reflect change of condition IPP meetings. A copy of this form is provided for department review. 2) The Clinical Coordinator will ensure that the type(s) of behaviors being targeted are specifically defined and included in the goals and objectives.	12/7/20 9/30/20

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T1645	Continued From page 4 to focus on his goals. Resident #1 came out of his room around 1:30 AM to use the bathroom on 1/6/17. At 1:45 AM, staff found Resident #1 climbing into Resident C-1's bed. Staff suggested he go back to his own room. Later in the day during a participant meeting, Resident #1 was notified by staff to keep his hands to himself when he touched Resident C-1's thigh. Resident #1 was found kissing Resident C-1 on 1/10/17. Staff documented they had educated Resident #1 on the consequences of his actions within the past week. A staff member and the Clinical Coordinator talked with Resident #1 about how his behavior could not continue without consequences. Resident #1 identified the reason for his behavior was boredom. Resident #1 was overheard making a plan with Resident C-1 to sneak into her bedroom on 1/11/17. On 1/13/17 it was documented Resident #1 entered Resident C-1's room without knocking. Staff told Resident #1 it was better to knock before entering, rather than walking into someone's room. They also encouraged him not to enter Resident C-1's room because of the recent issues he had with his behavior. On 1/14/17 at 5:30 AM, staff found Resident #1 in Resident C-1's bed hiding beneath the blankets. Resident #1 reported he had only been in the room for 20 seconds. A Personal Intervention Plan (PIP) for a doorbell was put in place for Resident #1 on 1/17/17 to address his impulse control as it related to female housemates he found attractive. A doorbell was affixed to Resident #1's bedroom door so staff would be alerted when he left his room, especially at night or when staff might be distracted. There was also a PIP for impulse control relating to female housemates which encouraged him to	T1645		

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T1645	Continued From page 5 keep his hands to himself. This plan was undated. A third PIP for positive interactions at home was also undated. None of these Personal Intervention Plans included goals or objectives. Resident #1 was seen kissing Resident C-1 in the hallway on 1/31/17. It was noted Resident #1 had been struggling with avoiding interaction with Resident C-1 despite several conversations with staff regarding the nature of the interactions and their conflicting purpose with Resident #1 being at the facility. Resident #1 was found in Resident C-1's bed on 2/1/17. Resident #1 left a note for Resident C-1 asking if she would help him masturbate on 2/21/17. When staff asked him about the note he reported Resident C-1 had rejected his advances. On 2/23/17, Resident #1 was seen snuggling up next to Resident C-1 while watching television. Staff noted it was difficult to advocate for him when he did not demonstrate he was working on his goals. Resident #1 attempted to get Resident C-1 to touch his genitals on 2/28/17. Resident #1 entered Resident C-1's room on 3/10/17 when she was asleep. Staff knocked on Resident C-1's door to wake her up and noticed Resident #1 was in the bedroom. Staff discussed boundaries with Resident #1 and encouraged him to leave the bedroom. It was documented on 3/13/17, staff initiated a conversation with Resident #1 about his actions and where he thought they would get him in the future. Staff redirected the conversation about Resident #1 and Resident C-1's sexual episode. Resident #1 was found in Resident C-1's bedroom at the end of the overnight shift on 3/18/17. Staff asked Resident #1 to leave the room which he did. On 3/20/17, Resident #1 was witnessed kissing Resident C-1 with his hands on her breasts and	T1645		

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T1645	Continued From page 6 vagina. Staff emphasized his actions did not belong at the facility because participants were there to work on their goals. Resident #1 was told his actions interfered with his own goals and the goals of his housemate. Staff stated no past interventions had worked and encouraged him to come up with his own interventions. Resident #1 admitted he struggled to control his behavior but stated it was part of his personality. He also said he would continue with the sexual interactions because he was bored. Resident #1 was found in Resident C-1's bed around 5:00 AM when she went to the bathroom. Resident #2 said he went to Resident C-1's bed because he was unable to sleep in his own bed. Resident C-1 was moved from a bedroom upstairs next to Resident #1 to a downstairs bedroom on 4/17/17. Resident #1 put his hand on Resident C-1's thigh on 4/22/17 and she asked him to stop. Resident #1 entered Resident #2's bedroom when she was napping on 4/23/18. He laid down on top of the covers, fully clothed. Staff knocked on the door, opened it and motioned for Resident #1 to exit the room. Resident #1 also appeared to touch Resident #2's rear end while in the kitchen. On 5/12/18, it was noted Resident #1 came out of his room at 3:20 PM, He was found at 3:26 PM in Resident C-1's bedroom. Resident C-1 was sleeping and Resident #1 was pulling up his pants when staff came into the room and asked him to leave. On 1/2/19, Resident #1 attempted to remove his bedroom doorbell speaker before going to his room for the night. Resident C-1 moved out of the facility on 2/18/19. As noted above, Resident #1 had a PIP dated 1/17/17 regarding a door bell for his bedroom door. The reason for the bell was due to the	T1645		

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T1645	Continued From page 7 resident's impulse control issues around female housemates he found attractive. He generally struggled with this impulse control during the night or when he believed staff were occupied. Staff were to respond to the door bell if it went off. He also had a PIP (undated) for impulse control. This PIP was essentially the same as the doorbell PIP, but included a gesture of holding his hands close to his chest as a physical reminder to keep his hands to himself. Neither of these PIPs included goals or specific objectives Record review on 9/21/20 revealed Resident #1 was admitted to the facility on 12/28/16. Quarterly Multidisciplinary Progress Reports since admission revealed a goal to utilize strategies to cope with cognitive deficits. The objectives were to decrease dis-inhibited behavior by utilizing coping skills as demonstrated by using compensatory strategies and to utilize effective decision making skills as demonstrated by using compensatory strategies. The goal did not include what types of dis-inhibited behaviors the resident struggled with, what compensatory strategies were to be utilized, or specific services provided to achieve the goal. A concrete goal addressing Resident #1's behaviors regarding Resident C-2 could not be located. The Chief Executive Officer, Clinical Director and Clinical Coordinator confirmed these findings during an interview on 9/30/20 at 3:30 PM.	T1645		