

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

ok

PRINTED: 11/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2024
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 WEST SHAULIS ROAD WATERLOO, IA 50701		
(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 Investigation #124289-I was completed on 10/23/24 to 11/6/24. Investigation #124289-I resulted in the determination of Immediate Jeopardy (IJ) on 10/30/24 at 4:49 p.m. based on facility failure to incorporate interventions for behavior in the individual program plan (IPP). As result Client #1 stole and ate a peanut butter and jelly sandwich, choked, and lost consciousness. Staff performed Heimlich thrusts to attempt to dislodge the stuck sandwich and upon losing Client #1's pulse staff performed CPR. Client #1 was hospitalized and ultimately passed away on 10/21/24. The facility developed and trained procedures to ensure all concerns identified on a client's comprehensive functional assessment (CFA) are incorporated into their programming. The IJ was removed on 10/31/24 at 12:56 p.m.	W 000	See Attached POC 12/6/24		
W 266	CLIENT BEHAVIOR & FACILITY PRACTICES CFR(s): 483.450 The facility must ensure that specific client behavior and facility practices 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	W 266			

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.

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

PRINTED: 11/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2024
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 WEST SHAULIS ROAD WATERLOO, IA 50701		
(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 266	Continued From page 1 the Condition of Participation (CoP) - Client Behaviors and Facility Practices. Findings follow: Cross reference W289: Based on interviews and record reviews, the facility failed to incorporate interventions for behavior into the individual program plan (IPP). Investigation #124289-I resulted in the determination of Immediate Jeopardy (IJ) on 10/30/24 at 4:49 p.m. based on facility failure to incorporate interventions for behavior in the individual program plan (IPP). As result Client #1 stole and ate a peanut butter and jelly sandwich, choked, and lost consciousness. Staff performed Heimlich thrusts to attempt to dislodge the stuck sandwich and upon losing Client #1's pulse staff performed CPR. Client #1 was hospitalized and ultimately passed away on 10/21/24. The facility developed and trained procedures to ensure all concerns identified on a client's comprehensive functional assessment (CFA) are incorporated into their programming. The IJ was removed on 10/31/24 at 12:56 p.m.	W 266			
W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to incorporate interventions for behavior into the individual program plan (IPP). This affected 1 of 1 client involved in investigation	W 289			

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

PRINTED: 11/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2024
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 WEST SHAULIS ROAD WATERLOO, IA 50701		
(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 289	<p>Continued From page 2</p> <p>#124289-I. Finding follows:</p> <p>The following findings resulted in the determination of Immediate Jeopardy (IJ) on 10/30/24 at 4:49 p.m. based on facility's failure to incorporate interventions for behavior in the individual program plan (IPP). As result Client #1 stole and ate a peanut butter and jelly sandwich, choked, and lost consciousness. Staff performed Heimlich thrusts to attempt to dislodge the stuck sandwich and upon losing Client #1's pulse staff performed CPR. Client #1 was hospitalized and ultimately passed away on 10/21/24. The facility developed and trained procedures to ensure all concerns identified on a client's comprehensive functional assessment (CFA) are incorporated into their programming. The IJ was removed on 10/31/24 at 12:56 p.m.</p> <p>Record review on 10/23/24 revealed Client #1's Incident Report (IR) dated 10/18/24, documented staff found Client #1 stuffing an entire peanut butter and jelly sandwich in her mouth. Client #1 started choking and staff initiated the Heimlich Maneuver.</p> <p>Record review on 10/23/24 revealed Client #1's progress note dated 10/21/24, documented the facility received notified from the Hospital Client #1 passed away on 10/21/24 at 5:37 p.m.</p> <p>Record review on 10/23/24 revealed Client #1 was a 45 year old woman with a diagnoses including moderate intellectual disability, autistic disorder, obsessive-compulsive personality disorder, unspecified disorder of adult personality and behavior, and sleep disorder. Client #1 ambulated on own and had a wheelchair for long distance and/or unsteadiness. Client #1 had a</p>	W 289			

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

PRINTED: 11/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2024
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 WEST SHAULIS ROAD WATERLOO, IA 50701		
(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 289	<p>Continued From page 3</p> <p>behavior program in place to address self-injurious behaviors.</p> <p>When interviewed on 10/23/24 at 3:19 p.m., Qualified Intellectual Disability Professional (QIDP) A confirmed Client #1 would successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust pans if the opportunity presented itself. QIDP A confirmed staff provided appropriate interventions for Client #1 including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food.</p> <p>When interviewed on 10/23/24 at 2:48 p.m., QIDP B confirmed she personally witnessed Client #1 successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust pans. QIDP B confirmed she provided interventions including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food. QIDP B confirmed Client #1 attempted or successfully stole food not intended for her at least a couple times every week.</p> <p>When interviewed on 10/24/24 at 9:15 a.m., Developmental Aide (DA) C confirmed she personally witnessed Client #1 successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust pans. DA C confirmed she provided interventions including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food. DA C confirmed Client #1 attempted or successfully stole food not intended for her at least a couple times every week.</p>	W 289			

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

PRINTED: 11/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2024
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 WEST SHAULIS ROAD WATERLOO, IA 50701		
(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 289	<p>Continued From page 4</p> <p>When interviewed on 10/24/24 at 9:15 a.m., the Social Worker (SW) confirmed she personally witnessed Client #1 successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust pans. The SW confirmed she provided interventions including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food. The SW confirmed Client #1 attempted or successfully stole food not intended for her at least a couple times every week.</p> <p>When interviewed on 10/24/24 at 10:50 a.m., Activity of Daily Living (ADL) Coordinator confirmed she personally witnessed Client #1 successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust pans. ADL Coordinator confirmed she provided interventions including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food. ADL Coordinator confirmed Client #1 attempted or successfully stole food not intended for her at least a couple times every week.</p> <p>When interviewed on 10/28/24 at 11:45 a.m., Registered Nurse (RN) confirmed she personally witnessed Client #1 successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust pans. RN confirmed she provided interventions to Client #1 including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food. RN confirmed Client #1 attempted or successfully stole food not intended for her at least a couple times every week.</p> <p>When interviewed on 10/29/24 at 8:00 a.m.,</p>	W 289			

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

PRINTED: 11/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2024
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 WEST SHAULIS ROAD WATERLOO, IA 50701		
(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 289	<p>Continued From page 5</p> <p>Respiratory Therapist (RT) confirmed she personally witnessed Client #1 successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust pans. RT confirmed she provided interventions including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food. RT confirmed Client #1 attempted or successfully stole food not intended for her at least a couple times every week.</p> <p>When interviewed on 10/30/24 at 12:58 p.m., DA Lead confirmed she personally witnessed Client #1 successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust pans. DA Lead confirmed she provided interventions including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food. DA Lead confirmed Client #1 attempted or successfully stole food not intended for her at least a couple times every week.</p> <p>When interviewed on 10/30/24 at 1:00 p.m., DA A confirmed she personally witnessed Client #1 successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust pans. DA A confirmed she provided interventions including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food. DA A confirmed Client #1 attempted or successfully stole food not intended for her at least a couple times every week.</p> <p>When interviewed on 10/30/24 at 1:02 p.m., DA B confirmed she personally witnessed Client #1 successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust</p>	W 289			

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

PRINTED: 11/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2024
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 WEST SHAULIS ROAD WATERLOO, IA 50701		
(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 289	<p>Continued From page 6</p> <p>pans. DA B confirmed she provided interventions including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food. DA B confirmed Client #1 attempted or successfully stole food not intended for her at least a couple times every week.</p> <p>When interviewed on 10/30/24 at 1:12 p.m., DA D confirmed she personally witnessed Client #1 successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust pans. DA D confirmed she provided interventions including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food. DA D confirmed Client #1 attempted or successfully stole food not intended for her at least a couple times every week.</p> <p>When interviewed on 10/30/24 at 1:53 p.m., DA E confirmed she personally witnessed Client #1 successfully steal food and/or attempt to steal food from peers' plates, trash cans, and dust pans. DA E confirmed she provided interventions including blocking, redirecting, physically removing food from her hand and mouth, and physically relocating her to not be around food. DA E confirmed Client #1 attempted or successfully stole food not intended for her at least a couple times every week.</p> <p>Additional record review on 10/29/24 revealed the following:</p> <p>a. Client #1's IR dated 5/12/24, documented Client #1 attempted to steal food.</p> <p>b. Client #1's comprehensive functional</p>	W 289			

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

PRINTED: 11/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2024
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 WEST SHAULIS ROAD WATERLOO, IA 50701		
(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 289	<p>Continued From page 7</p> <p>assessment (CFA) dated 7/23/24, indicated needed physical prompting to prevent taking items that didn't belong to her.</p> <p>c. Client #1's Behavior Intervention Program (BIP) dated 7/16/24, failed to include any information on how to prevent Client #1 from stealing food not intended for her or how or to respond when Client #1 attempted to take food not intended for her.</p> <p>d. Client #1's IPP dated 7/23/24, lacked any information on her stealing behavior. Continued review failed to review documentation Client #1 attempted to or took food not intended for her.</p> <p>e. Client #1's diet order dated 5/30/24, documented Client #1 was prescribed a soft and bite sized foods diet.</p> <p>When interviewed on 10/30/24 at 2:36 p.m., the Administrator confirmed stealing behaviors should have been addressed in Client #1's BIP.</p>	W 289			

Harmony House Healthcare Center
2950 W Shaulis Rd, Waterloo, IA 50701

Plan of Correction (POC) related to survey completed: 11/6/24

Date POC submitted to DIAL: 11/29/2024

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited or as an agreement that the facts stated by DIAL are accurate or complete. This plan of correction is prepared solely because it is required under federal or state law.

F000 Correction Date: 12/6/2024

W266 CLIENT BEHAVIOR & FACILITY PRACTICES CFR(s): 483.450

W289 MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4)

1. The Qualified Intellectual Disability Professional (QIDP) will monitor clients for behaviors consistent with not “asking” or seeking permission before taking items that do not belong to them. The QIDP will ensure the behavior is noted in the client’s CFA and that appropriate programming is in place or the rationale for not programming the behavior is noted in the client record. Clients will be reviewed by 12/6/2024. QIDPs will receive education and training regarding the aforementioned by 12/6/24.
2. The Program coordinator or designee will perform random audits monthly for 4 months of new client CFA’s to ensure the proper programming is in place prior to the 30 day staffing for clients who exhibit behaviors of not ask before taking items that do not belong to them. Through the facility’s quality assurance process, the frequency of audits thereafter will be determined by outcomes.