Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Number FC 6284		Report Date October 7, 2016
Facility Name Harmony House Health Care Center	Fine amount reduced to $3,250.00 On December 6, 2016 pursuant to Iowa Code Section 135C.43A	Survey Dates August 15-22, 2016 & September 6, 2016
Facility Address 2950 West Shaulis Road		Survey
City Waterloo, IA 50701	HL/CC	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
64.60	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.** **Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.** **This rule is intended to implement Iowa Code Section 135C.2(3).**	II	$500.00	Upon Receipt
W 302	**483.450(d)(4) PHYSICAL RESTRAINS** **A client placed in restraint must be released from the restraint as quickly as possible.** **DESCRIPTION :** Based on interviews and record review, the facility failed to ensure clients released from restrains as soon as the client was calm and no longer a danger to himself/herself or others. This affected 3 of 3 clients with use of 4-point restraint programs (Client #2, #14 and Client #48). Findings follow: 1. Record review on 8/18/16 revealed Client #14's behavior program to demonstrate appropriate behavior (decrease target behavior of aggression). Restrictive methods included the use of 4-point restraints. The			

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	programs stated, "Any aggressive incidents as listed above, or attempted aggression with the intention of causing harm to others will be consequated with the immediate application of 4 pt. (point) restraints to (his/her) wrists and ankles for a 2 hr. period following QIDP authorization." The program said staff would monitor Client #14 every 15 minutes during the 4-point restraints. "At the conclusion of the restraint period, the restraints will be removed from (Client #14's) wrist and ankles and staff will provide (him/her) with any assistance (he/she) may have." The program and the written informed consent both stated Client #14 would be in the 4-point restraints for a 2 hour time period, with no information indicating the client could be released sooner if calm. Additional record review revealed 4-point restraints were added to Client #14's behavior program on 6/15/16. Review of Client #14's restraint logs revealed the client had been in 4-point restraints 31 times since 6/15/16. Client #14 was in 4-point restraints for 2 hours each time. Many of the restraint logs noted Client #14 as calm or even sleeping during the 15 minute checks. Examples included, but were not limited to the following: a. On 7/18/16, Client #14 hit staff which required the use of the 4 point restraint. The client's activity prior to the behavior identified staff redirected the client from taking other residents special drinks and supplements. Staff restrained both Client #14's feet and right/left wrist. Client #14 started swinging his/her left arm around when staff attempted to restrain his/her left wrist. The restraint form identified Client #14 remained restrained from 11:30 a.m. to 1:30 p.m., and the first behavior check documented the client had his/her eyes open, on his/her left side incontinent of urine. Staff identified Client #14's behavior at the second and third 15			

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	minute check as eyes open and quiet. The fourth 15 minute check, Client #14 had been quiet, and falling asleep. At the fifth check, Client #14 had been calm and his/her eyes opened when the door first opened. At the 6th check, the client had been calm and quiet. At the 7th check, the client laid on his/her side and briefly opened his/her eyes. When staff removed the restraint at 1:30 p.m., staff documented "soiled him/her(self), got clothes and took shower." b. On 7/11/16, Client #14 attempted to hit staff (took a swing at staff) which required the use of the 4 point restraint. The client's activity prior to the behavior identified he/she had been getting ready [dressed] to go to breakfast and wanted a belt. Staff told the client there wasn't a belt available and staff asked Client #14 to go eat breakfast. The restraint form showed Client #14 remained restrained from 8:48 a.m. to 10:48 a.m., with staff completing 15 minute checks during this time. Staff identified Client #14's behavior at the first 15 minute check as resting, calm lying on the left side. At the 2nd 15 minute check, Client #14 asked "when are you going to get me [up]" and had been calm with his/her eyes open. At the third, fourth, fifth 15 minute checks, Client #14 remained calm with his/her eyes open. At the 6th check, the client stated, "I need help." At the 7th check, the client stated "I need help getting out of these things." c. On 7/14/16, Client #14 attempted to hit staff and was placed in 4-point restraints as a result. The client's activity prior to the behavior identified he/she was prompted by staff to stay awake so he/she slept at night. The restraint form documented Client #14 restrained by 4-points from 10:00 a.m. until 12:00 p.m. The first check noted Client #14 lying on his/her side, quiet with eyes open. The 2nd and 3rd checks noted Client #14 lying quietly on his/her side asleep and awaking when the restraints were checked. During the			

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	4th check, Client #14 lay quietly with eyes open and asked to take a shower. The 5th and 6th checks documented Client #14 laid on his/her side and slept, waking when the restraints were checked. The 7th check noted Client #14 laid on his/her side quietly with eyes open. d. On 8/1/16, Client #14 attempted to hit staff and was placed in 4-point restraints as a result. The form documented prior to the behavior, Client #14 asked staff to walk in the courtyard with him/her and was calm. When Client #14 saw another group going to the Life Skills building and found out it wasn't his/her group's turn, he/she walked a little way from life skills, then told staff, "I want you to leave." The form indicated staff responded by coming out with a mat and Client #14 went out the gate and walked away, but eventually walked into the building with a mat around him/her. Initially reluctant, Client #14 complied with 4-point restraint application. Client #14 remained 4-point restraints from 5:47 p.m. until 7:47 p.m. All seven checks noted Client #14 laid quietly with his/her eyes open. During the 2nd check, Client #14 told staff, "I'm ready to get out." During the 4th check, Client #14 gave a brief, quiet high-pitched vocalization. e. On 7/15/16, Client #14 was placed in 4-point restraints from 1:01 p.m. to 3:01 p.m. The restraint form failed to identify the behavior requiring 4-point restraint use, as well as Client #14's activity prior to the behavior. The form indicated Client #14 was compliant with application of the restraints. The form documented during the first and second checks, Client #14 laid quietly. During the 3rd check, he/she laid calmly and said, "wanna get out now." At fourth check, he/she laid calmly and said, "I'm ready to get out now." Client #14 laid quietly during the fifth check. During the sixth check, he/she said "I'm ready to get out.			

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	I'll behave." At seventh check, he/she said, "I want to get out." f. On 8/14/16 the first and second 15 minute checks noted Client #14 "laying quietly on bed;" the third check noted the client laying on the bed calm and asking if he/she could get up, to which he/she was told no; the fourth and fifth checks noted the client laying on the bed, calm and quiet; the sixth and seventh checks noted the client slept. g. On 8/09/16, During first 15 minute check Client #14 laid on his/her side, calm and quiet; during second check client said he/she did not want to eat breakfast; during first, second, third, fourth, fifth, sixth and seventh check client laid quietly. h. On 7/30/16, during first, second, third, fourth, fifth, sixth and seventh 15 minute check Client #14 laid quietly on bed. 2. Record review on 8/17/16 revealed Client #48's behavior plan to reduce aggression. Restrictive methods included the use of 4-point restraints. The plan stated Client #48 would remain in the 4-point restraints for a maximum of 2 hours, with visual checks every 15 minutes. The program did not include any information regarding when or if Client #48 could be released when calm, prior to the 2 hour maximum. The 4-point restraint had been added to the program on 5/31/16. Review of restrain logs from 6/02/16 to 8/14/16 revealed 29 restraint logs for 4-point restraints. All restraint logs revealed Client #48 had been in the 4-point restraints for two hours. Many of the restraint logs noted Client #48 as			

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	calm or even sleeping during the 15 minute checks. Examples included, but were not limited to the following: a. On 7/13/16, Client #48 was placed in 4-point restraints at 4:05 p.m. The restraint form failed to identify the behavior for which the restraint application was necessary. The form also failed to identify the client's activity prior to placement in 4-point restraints. The form documented during the first, second, third, fourth, and fifth checks Client #48 laid quietly. During the sixth check, Client #48 worked to release himself/herself from the restraints. During the seventh check, he/she was redirected back to the restraint. Upon release the resident asked for dinner and was told he/she could only have a Breeze (nutritional supplement), because dinner was over. b. On 6/2/16, Client #48 remained restrained from 6:40 p.m. to 8:40 p.m., with staff completing 15 minute checks during this time. According to the restraint form, at the first check at 6:55 p.m., second check at 7:10 p.m., and third check completed at 7:25 p.m., Client #48 remained quiet and laid flat on his/her back. At the 4th check, Client #48 stated, "let me out, please" and lifted his/her head up and asked "what are you doing?" There was a small amount of blood on the client's left finger from picking his/her fingernail. Staff notified the nursing staff. At the fifth check, Client#48 sat up in bed and said, "It's not nice to put these on me." During the sixth behavior check at 8:10 p.m., Client #48 laid on his/her back, appeared calm, and also quiet. At 8:25 p.m., the 7th check, the client remained quiet except when he/she asked staff what they were doing. Upon removal of the restraints at 8:40 p.m., Client #48 asked for a snack and sat at the table. c. Also on 6/2/16, at 9:05 p.m., Client #48 took his/her medications and demanded a snack. Staff told him/her no and offered a drink as snack time was over. Client #48			

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	pulled staff's stethoscope around staff's neck and then hit staff. The restraint form showed Client #48 restrained from 9:05 p.m. to 11:05 p.m., with staff completing 15 minute checks during this time. At the first, second, third and fourth 15 minute checks, staff documented Client #48 quiet. At the fifth, sixth and 7th 15 minute check, staff documented Client #48 asleep. d. On 8/14/1, the first 15 minute check noted Client #48 "calm and quiet;" the second check noted the client "quiet"; the third, fourth, fifth and sixth 15 minute checks noted Client #48 slept; the seventh check noted the client awake and talking. e. On 8/11/16, the first, second and third 15 minute checks noted Client #48 "quiet and calm;" the fourth and fifth checks noted the client slept; the sixth and seventh checks documented the client as calm and quiet. f. On 8/07/16, the first 15 minute check documented the client asked for the right wrist strap to be adjusted because it hurt, so staff adjusted it; the second, third and fourth checks noted the client "laying quietly"; the fifth, sixth, and seventh checks documented the client appeared to sleep. g. On 7/30/16, the first, second, third, fourth, and fifth 15 minute checks noted client "laying calmly, quietly"; the sixth check noted the client "sitting up in bed, staring at staff," the seventh check noted the client laying quietly. h. On 7/21/16 Client #48 was noted to be quiet or asleep on all 15 minute checks. When interviewed on 8/17/16 at 10:30 a.m. the PC/QIDP			

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	acknowledged Client #48's behavior program for aggression did not provide any criteria for release from the 4-point restraints prior to the 2 hour maximum. She said Client #48 was always put into the 4-point restraints for 2 hours, regardless of showing signs of being calm. 3. Record review on 8/16/16 revealed Client #2's behavior plan to problem solve and decrease aggression, self-injurious behaviors, property destruction and environmental disruption. Methods included use of 4-point restraints. The program directed staff to conduct visual checks every 15 minutes and to release Client #2 from restraints after 1 hour and 15 minutes, if Client #2 was calm and not struggling against the restraints, with a maximum of 2 hour restraint. According to Client #2's Behavior Intervention History, 4-point restraints were added to his/her behavior program on 5/9/11. The length of time in 4-point restraints was increased to 2 hours on 4/17/13. Further review revealed Client #2 had eight restraint logs for 4-point restraints between 6/07/16 to 8/08/16. On six of the eight restraint logs, the 15 minute checks indicated Client #2 was not calm prior during the majority of the checks, but was released when calm after the 1 hour and 15 minute time period. Two of the restraint logs revealed Client #2 appeared calm during the 1 hour and 15 minute time period, but was not released. a. Record review on 8/18/16 revealed Client #2's restraint use form dated 7/25/16. The form noted staff placed Client #2 in 4-point restraints at 7:45 p.m. and conducted visual checks every 15 minutes until 9:00 p.m. Documentation of Client #2's behavior at 8:45 p.m. noted			

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	"Quiet, not pulling at restraints." Further documentation at 9:00 p.m. read "Quiet" and finally "Released" with no time indicated. b. Review of a restraint use form dated 7/28/16 revealed staff placed Client #2 in 4-point restraints at 4:45 p.m. Staff documentation noted: 5:30 p.m. he/she rested on his/her side, quiet and "playing" with straps; 5:45 p.m. "had nails clipped" and apologized to staff; 6:00 p.m. calm, and final documentation stated "out" with no time noted. When interviewed on 8/18/17 at 9:55 a.m., the Program Coordinator/Qualified Intellectual Disability Professional (PC/QIDP) stated Client #2 remained in 4-point restraints for 1 hour and 15 minutes regardless of when he/she calmed and/or ceased maladaptive behavior(s). The above findings led to the determination of an Immediate Jeopardy on 8/18/16 based on the facility's failure to ensure the safety and protection of the Client #2, #14, and #48 and their civil and human rights. The Immediate Jeopardy was abated on 8/18/16 at 4:50 p.m. **FACILITY RESPONSE:**			

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W127	**483.420(a)(5) PROTECTION OF CLIENTS RIGHTS** **The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.** **DESCRIPTION:** Based on interview and record review, the facility failed to ensure the development and implementation of adequate systems to identify and prevent abuse and/or mistreatment of clients. The facility failed to proactively assure clients were free from threats to their physical and psychological health, specifically regarding the use of restrictive/intrusive behavior management techniques. The facility utilized behavior management techniques in a punitive manner with disregard for the welfare and civil and human rights of clients served. This affected 3 of 3 clients (Client #2, #14, and #48)whose individual program plans included the use of four-point restraints.			

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	Findings follow: 1. Record review on 8/18/16 revealed Client #14's behavior program to demonstrate appropriate behavior (decrease target behavior of aggression). For first and second shift, the program directed, "Any aggressive incidents as listed above, or attempted aggression with the intention of causing harm to others will be consequated with the immediate application of 4 pt. (point) restraints to (his/her) wrists and ankles for a 2 hr. period following QIDP authorization." The program said staff would monitor Client #14 every 15 minutes during the 4-point restraints. "At the conclusion of the restraint period, the restraints will be removed from (Client #14's) wrist and ankles and staff will provide (him/her) with any needs (he/she) may have." The program and the written informed consent both stated Client #14 would be in the 4-point restraints for a 2 hour time period, with no information indicating the client could be released sooner if calm. Additional record review revealed 4-point restraints were added to Client #14's behavior program on 6/15/16. Review of Client #14's restraint logs revealed the client had been in 4-point restraints 31 times since 6/15/16. Client #14 was in 4-point restraints for 2 hours each time. Many of the restraint logs noted Client #14 as calm or even sleeping during the 15 minute checks. Examples included, but were not limited to the following: a. On 7/18/16, Client #14 hit staff which required the use of the 4 point restraint. The client's activity prior to the behavior identified staff redirected the client from taking other residents special drinks and supplements. Staff restrained both Client #14's feet and right/left wrist. Client #14 started swinging his/her left arm around when staff attempted to			

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	restrain his/her left wrist. The restraint form identified Client #14 remained restrained from 11:30 a.m. to 1:30 p.m., and the first behavior check documented the client had his/her eyes open, on his/her left side incontinent of urine. Staff identified Client #14's behavior at the second and third 15 minute check as eyes open and quiet. The fourth 15 minute check, Client #14 had been quiet, and falling asleep. At the fifth check, Client #14 had been calm and his/her eyes opened when the door first opened. At the 6th check, the client had been calm and quiet. At the 7th check, the client laid on his/her side and briefly opened his/her eyes. When staff removed the restraint at 1:30 p.m., staff documented "soiled him/her(self), got clothes and took shower." b. On 7/11/16, Client #14 attempted to hit staff (took a swing at staff) which required the use of the 4 point restraint. The client's activity prior to the behavior identified he/she had been getting ready [dressed] to go to breakfast and wanted a belt. Staff told the client there wasn't a belt available and staff asked Client #14 to go eat breakfast. The restraint form showed Client #14 remained restrained from 8:48 a.m. to 10:48 a.m., with staff completing 15 minute checks during this time. Staff identified Client #14's behavior at the first 15 minute check as resting, calm lying on the left side. At the 2nd 15 minute check, Client #14 asked "when are you going to get me [up]" and had been calm with his/her eyes open. At the third, fourth, fifth 15 minute checks, Client #14 remained calm with his/her eyes open. At the 6th check, the client stated, "I need help." At the 7th check, the client stated "I need help getting out of these things." c. On 7/14/16, Client #14 attempted to hit staff and was placed in 4-point restraints as a result. The client's activity prior to the behavior identified he/she was prompted by staff to stay awake so he/she slept at night. The restraint form			

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	documented Client #14 restrained by 4-points from 10:00 a.m. until 12:00 p.m. The first check noted Client #14 lying on his/her side, quiet with eyes open. The 2nd and 3rd checks noted Client #14 lying quietly on his/her side asleep and awaking when the restraints were checked. During the 4th check, Client #14 lay quietly with eyes open and asked to take a shower. The 5th and 6th checks documented Client #14 laid on his/her side and slept, waking when the restraints were checked. The 7th check noted Client #14 laid on his/her side quietly with eyes open. d. On 8/1/16, Client #14 attempted to hit staff and was placed in 4-point restraints as a result. The form documented prior to the behavior, Client #14 asked staff to walk in the courtyard with him/her and was calm. When Client #14 saw another group going to the Life Skills building and found out it wasn't his/her group's turn, he/she walked a little way from life skills, then told staff, "I want you to leave." The form indicated staff responded by coming out with a mat and Client #14 went out the gate and walked away, but eventually walked into the building with a mat around him/her. Initially reluctant, Client #14 complied with 4-point restraint application. Client #14 remained 4-point restraints from 5:47 p.m. until 7:47 p.m. All seven checks noted Client #14 laid quietly with his/her eyes open. During the 2nd check, Client #14 told staff, "I'm ready to get out." During the 4th check, Client #14 gave a brief, quiet, high-pitched vocalization. e. On 7/15/16, Client #14 was placed in 4-point restraints from 1:01 p.m. to 3:01 p.m. The restraint form failed to identify the behavior requiring 4-point restraint use, as well as Client #14's activity prior to the behavior. The form indicated Client #14 was compliant with application of the restraints. The form documented during the first and second checks, Client #14 laid quietly. During the 3rd check, he/she laid calmly and said, "wanna get out now."			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
	At fourth check, he/she laid calmly and said, "I'm ready to get out now." Client #14 laid quietly during the fifth check. During the sixth check, he/she said "I'm ready to get out. I'll behave." At seventh check, he/she said, "I want to get out." f. On 8/9/16, Client #14 slept in bed. Staff prompted Client #14 to go to breakfast, and he/she attempted to hit them, resulting in application of 4-point restraints. The client complied with restraint application. During the first check, the document noted, "on left side, calm, quiet." During the 2nd check, Client #14 told staff, "I don't want to eat breakfast this morning." The 3rd, 4th, 5th, 6th, and 7th checks noted Client #14 laid quietly. g. On 8/14/16, the document noted Client #14 got into restraints on his/her own, as he/she was "very calm." The first and second 15 minute checks noted Client #14 "laying quietly on bed;" the third check noted the client laying on the bed calm and asking if he/she could get up, to which he/she was told no; the fourth and fifth checks noted the client laying on the bed, calm and quiet; the sixth and seventh checks noted the client slept. h. On 8/2/16 the document noted Client #14 "compliant in going into restraint." During the first check, Client #14 laid quietly with eyes open. During the second check, Client #14 slept. The client woke during the third and fourth checks when staff completed checks. He/she laid with eyes open during the fifth and sixth checks, and woke during he seventh check. Documentation noted Client #14 prompted to go to lunch upon removal, which he/she declined to sleep instead.			

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Administrator Date

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

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	i. On 7/30/16, the document noted Client #14's response to intervention as "quiet, calm." During first, second, third, fourth, fifth, sixth and seventh 15 minute check Client #14 laid quietly on bed. 2. Record review on 8/17/16 revealed Client #48's behavior plan to reduce aggression. The program directed Client #48 would be put into four-point restraints upon first incident of aggression or attempted aggression. The plan stated Client #48 would remain in the 4-point restraints for a maximum of 2 hours, with visual checks every 15 minutes. The program did not include any information regarding when or if Client #48 could be released when calm, prior to the 2 hour maximum. The 4-point restraint had been added to the program on 5/31/16. Review of restraint logs from 6/02/16 to 8/14/16 revealed 29 restraint logs for 4-point restraints. All restraint logs revealed Client #48 had been in the 4-point restraints for two hours. Many of the restraint logs noted Client #48 as calm or even sleeping during the 15 minute checks. Examples included, but were not limited to the following: a. On 7/13/16, Client #48 was placed in 4-point restraints at 4:05 p.m. The restraint form failed to identify the behavior for which the restraint application was necessary. The form also failed to identify the client's activity prior to placement in 4-point restraints. The form documented during the first, second, third, fourth, and fifth checks Client #48 laid quietly. During the sixth check, Client #48 worked to release himself/herself from the restraints. During the seventh check, he/she was redirected back to the restraint. Upon release the resident asked for dinner and was told he/she could only have a Breeze (nutritional supplement),			

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	because dinner was over. b. On 6/2/16, Client #48 remained restrained from 6:40 p.m. to 8:40 p.m., with staff completing 15 minute checks during this time. According to the restraint form, at the first check at 6:55 p.m., second check at 7:10 p.m., and third check completed at 7:25 p.m., Client #48 remained quiet and laid flat on his/her back. At the 4th check, Client #48 stated, "let me out, please" and lifted his/her head up and asked "what are you doing?" There was a small amount of blood on the client's left finger from picking his/her fingernail. Staff notified the nursing staff. At the fifth check, Client#48 sat up in bed and said, "It's not nice to put these on me." During the sixth behavior check at 8:10 p.m., Client #48 laid on his/her back, appeared calm, and also quiet. At 8:25 p.m., the 7th check, the client remained quiet except when he/she asked staff what they were doing. Upon removal of the restraints at 8:40 p.m., Client #48 asked for a snack and sat at the table. c. Also on 6/2/16, at 9:05 p.m., Client #48 took his/her medications and demanded a snack. Staff told him/her no and offered a drink as snack time was over. Client #48 pulled staff's stethoscope around staff's neck and then hit staff. The restraint form showed Client #48 restrained from 9:05 p.m. to 11:05 p.m., with staff completing 15 minute checks during this time. At the first, second, third and fourth 15 minute checks, staff documented Client #48 quiet. At the fifth, sixth and 7th 15 minute check, staff documented Client #48 asleep. d. On 8/14/16, the first 15 minute check noted Client #48 "calm and quiet;" the second check noted the client "quiet"; the third, fourth, fifth and sixth 15 minute checks noted Client #48 slept; the seventh check noted the client			

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	awake and talking. e. On 8/11/16, the first, second and third 15 minute checks noted Client #48 "quiet and calm;" the fourth and fifth checks noted the client slept; the sixth and seventh checks documented the client as calm and quiet. f. On 8/07/16, the first 15 minute check documented the client asked for the right wrist strap to be adjusted because it hurt, so staff adjusted it; the second, third and fourth checks noted the client "laying quietly"; the fifth, sixth, and seventh checks documented the client appeared to sleep. g. On 7/30/16, the first, second, third, fourth, and fifth 15 minute checks noted client "laying calmly, quietly"; the sixth check noted the client "sitting up in bed, staring at staff," the seventh check noted the client laying quietly. h. On 7/21/16 Client #48 was noted to be quiet or asleep on all 15 minute checks. When interviewed on 8/17/16 at 10:30 a.m. the PC/QIDP acknowledged Client #48's behavior program for aggression did not provide any criteria for release from the 4-point restraints prior to the 2 hour maximum. She said Client #48 was always put into the 4-point restraints for 2 hours, regardless of showing signs of being calm. 3. Record review on 8/16/16 revealed Client #2's behavior plan to problem solve and decrease aggression, self-injurious behaviors, property destruction and environmental disruption. The program identified the use of 4-point restraints upon the first incident of engaging in			

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	maladaptive behavior. After obtaining approval from the Qualified Intellectual Disabilities Professional (QIDP), Client #2 would be place in 4-point restraints using the least amount of staff possible. If on the unit, staff would bring the bed with the restraints to Client #2 for application. The program directed staff to utilize a sheet or blanket to cover the restraints while taking the client to his/her bedroom. The program directed staff to conduct visual checks every 15 minutes and to release Client #2 from restraints after 1 hour and 15 minutes, if Client #2 was calm and not struggling against the restraints, with a maximum of 2 hour restraint. According to Client #2's Behavior Intervention History, 4-point restraints were added to his/her behavior program on 5/9/11. The length of time in 4-point restraints was increased to 2 hours on 4/17/13. Further review revealed Client #2 had eight restraint logs for 4-point restraints between 6/7/16 to 8/8/16. On six of the eight restraint logs, the 15 minute checks indicated Client #2 was not calm during the majority of the checks, but was released when calm after the 1 hour and 15 minute time period. Two of the restraint logs revealed Client #2 appeared calm during the 1 hour and 15 minute time period, but was not released. Record review on 8/18/16 revealed Client #2's restraint use form dated 7/25/16. The form noted staff placed Client #2 in 4-point restraints at 7:45 p.m. and conducted visual checks every 15 minutes until 9:00 p.m. Documentation of Client #2's behavior at 8:45 p.m. noted "Quiet, not pulling at restraints." Further documentation at 9:00 p.m. read "Quiet" and finally "Released" with no time			

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	indicated. Review of a restraint use form dated 7/28/16 revealed staff placed Client #2 in 4-point restraints at 4:45 p.m. Staff documentation noted: 5:30 p.m. he/she rested on his/her side, quiet and "playing" with straps; 5:45 p.m. "had nails clipped" and apologized to staff; 6:00 p.m. calm, and final documentation stated "out" with no time noted. When interviewed on 8/18/17 at 9:55 a.m., the Program Coordinator/Qualified Intellectual Disability Professional (PC/QIDP) stated Client #2 remained in 4-point restraints for 1 hour and 15 minutes regardless of when he/she calmed and/or ceased maladaptive behavior(s). The above findings led to the determination of an Immediate Jeopardy on 8/18/16 based on the facility's failure to ensure the safety and protection of the Client #2, #14, and #48 and their civil and human rights. The Immediate Jeopardy was abated on 8/18/16 at 4:50 p.m. 4. Record review revealed Client #2's individual program plan to address prevocational behavior, with an goal to not need removed from an area of the center. Methods of the program directed if Client #2 engaged in maladaptive behaviors (including but not limited to: hitting or kicking others, biting, scratching others, and throwing objects), attempted to aggress towards others, engaged in self-injurious behavior, property destruction, or environmental hazard, he/she would be moved to another room. The program directed staff to utilize a mat as a barrier to assist with moving the client to the room. After 1 hour and 15 minutes, Client #2 could leave the room if calm and no longer showing signs of maladaptive behavior. The client could stay in the room no longer than two hours. The program directed staff to leave the room one by one and stand outside the door, which should be closed.			

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	5. Record review on 8/17/18 revealed Client #48's behavior program for emotional control with an objective to not require help to the quiet area more than five times for two consecutive months. The program directed if Client #48 became aggressive, staff should use mats to assist Client #48 to the calm room. The program further noted, "Once in the calm room staff may exit and sit outside the room. If (Client #48) attempts to leave before 15 minutes, (he/she) will be reminded to finish (his/her) calm down time. (He/she) may remain in the calm area no more than 2 hours, but may come out after fifteen minutes or as soon as (he/she) is calm after 15 minutes." Record review on 8/17/18 revealed a written informed consent for Client #48's emotional control program. According to the consent, "Staff will keep the door closed to the room so others do not see the behavior and to give (Client #48) less to stimulate from. Time in the calm room will be a minimum of 15 minutes with a ceiling of 2 hours. If (Client #48) attempts to leave the room before 15 minutes is up, staff will remind (him/her) to remain a bit longer. Staff will remain outside the door, listening for movements, statements, etc." When interviewed on 8/17/16 at 12:00 p.m. DA B said staff shut the door when Client #48 went into the Calm Room and then staff stood outside the door. When interviewed on 8/17/16 at 12:05 p.m. the Prevocational Coordinator (PVC)/QIDP confirmed staff shut the door and prevented Client #48 from leaving the Calm Room until the client was calm for 15 minutes. **FACILITY RESPONSE:**			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
64.60	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.** **Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.** **This rule is intended to implement Iowa Code Section 135C.2(3).**	II	$500.00	Upon Receipt
W104	**483.410(a)(1) GOVERING BODY** **The governing body must exercise general policy, budget, and operating direction over the facility.** **DESCRIPTION:** Based on observations, interviews and record review, the facility failed to provide adequate oversight and direction to ensure the safety and protection of civil and human rights of clients during implementation of behavior management techniques. This potentially affected 50 of 50 clients (Client #1 - Client #50) residing at the facility. Findings follow: 1. See W285, W295, and W302 for additional information. a. Record review on 8/18/16 revealed Client #14's behavior program to demonstrate appropriate behavior (decrease target behavior of aggression). Restrictive methods included the use of 4-point restraints. The			

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	program directed, "Any aggressive incidents as listed above, or attempted aggression with the intention of causing harm to others will be consequated with the immediate application of 4 pt. (point)restraints to (his/her) wrists and ankles for a 2 hr. period following QIDP authorization." The program directed staff to monitor Client #14 every 15 minutes during the 4-point restraints. "At the conclusion of the restraint period, the restraints will be removed from (Client #14's) wrist and ankles and staff will provide (him/her) with any needs (he/she) may have." The program and the written informed consent both indicated Client #14 would be in the 4-point restraints for a 2 hour time period, with no information indicating the client could be released sooner if calm. Additional record review revealed 4-point restraints were added to Client #14's behavior program on 6/15/16. Review of Client #14's restraint logs revealed the client had been in 4-point restraints 31 times since 6/15/16. Client #14 was in 4-point restraints for 2 hours each time. Many of the restraint logs noted Client #14 as calm or even sleeping during the 15 minute checks. b. Record review on 8/17/16 revealed Client #48's behavior plan to reduce aggression. Restrictive methods included the use of 4-point restraints. The plan indicated Client #48 would remain in the 4-point restraints for a maximum of 2 hours, with visual checks every 15 minutes. The program did not include any information regarding when or if Client #48 could be released when calm, prior to the 2 hour maximum. The 4-point restraint had been added to the program on 5/31/16. Review of restraint logs from 6/02/16 to 8/14/16 revealed			

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	29 restraint logs for 4-point restraints. All restraint logs revealed Client #48 had been in the 4-point restraints for two hours. Many of the restraint logs noted Client #48 as calm or even sleeping during the 15 minute checks. When interviewed on 8/17/16 at 10:30 a.m. the PC/QIDP acknowledged Client #48's behavior program for aggression did not provide any criteria for release from the 4-point restraints prior to the 2 hour maximum. She said Client #48 was always put into the 4-point restraints for 2 hours, regardless of showing signs of being calm. c. Record review on 8/16/16 revealed Client #2's behavior plan to problem solve and decrease aggression, self-injurious behaviors, property destruction and environmental disruption. Methods included use of 4-point restraints. The program directed staff to conduct visual checks every 15 minutes and to release Client #2 from restraints after 1 hour and 15 minutes, if Client #2 was calm and not struggling against the restraints, with a maximum of 2 hour restraint. According to Client #2's Behavior Intervention History, 4-point restraints were added to his/her behavior program on 5/9/11. The length of time in 4-point restraints was increased to 2 hours on 4/17/13. Further review revealed Client #2 had eight restraint logs for 4-point restraints between 6/07/16 to 8/08/16. On six of the eight restraint logs, the 15 minute checks indicated Client #2 was not calm during the majority of the checks, but was released when calm after the 1 hour and 15 minute time period. Two of the restraint logs revealed Client #2 appeared calm during the 1 hour and 15 minute time period, but was not released.			

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	When interviewed on 8/18/17 at 9:55 a.m., the Program Coordinator/Qualified Intellectual Disability Professional (PC/QIDP) stated Client #2 remained in 4-point restraints for 1 hour and 15 minutes regardless of when he/she calmed and/or ceased maladaptive behavior(s). 2. See W291 and W293 for additional information. a. Observation of the "Calm Room" on 8/17/16 at 12:10 p.m. revealed the Calm Room had a wooden door with no window or peep hole. When the door was closed it was not possible to see into the Calm Room. The size of the room was approximately 14 feet by 9 feet. The walls were plaster or sheet rock. The floor had a thin carpet. Two sets of fluorescent lights were on the ceiling with thin plastic coverings. An uncovered electrical outlet was on one wall. Two small tables and three chairs were also in the room. There was a hole in one of the walls, about the size of a fist, and one of the staff stated Client #48 had punched the hole in the wall. Staff was present at the time of the incident. Record review on 8/17/18 revealed Client #48's behavior program for emotional control with an objective to not require help to the quiet area more than five times for two consecutive months. The program directed if Client #48 became aggressive, staff should use mats to assist Client #48 to the calm room. The program further noted, "Once in the calm room staff may exit and sit outside the room. If (Client #48) attempts to leave before 15 minutes, (he/she) will be reminded to finish (his/her) calm down time. (He/she) may remain in the calm area no more than 2 hours, but may come out after fifteen minutes or as soon			

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	as (he/she) is calm after 15 minutes." Record review on 8/17/18 revealed a written informed consent for Client #48's emotional control program. According to the consent, "Staff will keep the door closed to the room so others do not see the behavior and to give (Client #48) less to stimulate from. Time in the calm room will be a minimum of 15 minutes with a ceiling of 2 hours. If (Client #48) attempts to leave the room before 15 minutes is up, staff will remind (him/her) to remain a bit longer. Staff will remain outside the door, listening for movements, statements, etc." When interviewed on 8/17/16 at 12:00 p.m. DA B said staff shut the door when Client #48 went into the Calm Room and then staff stood outside the door. When interviewed on 8/17/16 at 12:05 p.m. the Prevocational Coordinator (PVC)/QIDP confirmed staff shut the door and prevented Client #48 from leaving the Calm Room until the client was calm for 15 minutes. b. Record review revealed Client #2's individual program plan to address prevocational behavior, with an goal to not need removed from an area of the center. Methods of the program directed if Client #2 engaged in maladaptive behaviors (including but not limited to: hitting or kicking others, biting, scratching others, and throwing objects), attempted to aggress towards others, engaged in self-injurious behavior, property destruction, or environmental hazard, he/she would be moved to another room. The program directed staff to utilize a mat as a barrier to assist with moving the client to the room. After 1 hour and 15 minutes, Client #2 could leave the room if calm and no			

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	longer showing signs of maladaptive behavior. The client could stay in the room no longer than two hours. The program directed staff to leave the room one by one and stand outside the door, which should be closed. **FACILITY RESPONSE:**			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
64.60	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.** **Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.** **This rule is intended to implement**	II	$500.00	Upon Receipt
W125	**483.420(a)(3) PROTECTION OF RIGHTS** **The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.** **DESCRIPTION:** Based on observation, interviews, and record reviews the facility failed to ensure client rights were protected as evidenced by failure to consistently ensure current written informed consents obtained for restrictive measures, reduction plans in place for restrictive measures utilized, and removal from restraints as soon as possible. This affected 5 of 8 sample clients with restrictive measures (Client #2, #31, #35, #41, and #48) and 2 clients added to the sample (Client #12 and #14). Findings follow: 1. Record review on 8/18/16 revealed Client #14's			

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Administrator Date

Number FC 6284		Report Date October 7, 2016
Facility Name Harmony House Health Care Center	Fine amount reduced to $3,250.00 On December 6, 2016 pursuant to Iowa Code Section 135C.43A	Survey Dates August 15-22, 2016 & September 6, 2016
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City Waterloo, IA 50701	HL/CC	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
	behavior program to demonstrate appropriate behavior (decrease target behavior of aggression). Restrictive methods included the use of 4-point restraints. The programs stated, "Any aggressive incidents as listed above, or attempted aggression with the intention of causing harm to others will be consequated with the immediate application of 4 pt. (point) restraints to (his/her) wrists and ankles for a 2 hr. period following QIDP authorization." The program directed staff to monitor Client #14 every 15 minutes during the 4-point restraint. "At the conclusion of the restraint period, the restraints will be removed from (Client #14's) wrist and ankles and staff will provide (him/her) with any assistance (he/she) may have." The program and the informed written consent both indicated Client #14 would be in the 4-point restraints for a 2 hour time period, with no information indicating the client could be released sooner if calm. Additional record review revealed 4-point restraints were added to Client #14's behavior program on 6/15/16. Review of Client #14's restraint forms revealed the client had been in 4-point restraints 31 times since 6/15/16. Client #14 was in 4 point restraints for two hours each time. Many restraint logs noted Client #14 as calm or even asleep during 15 minute checks. Examples included, but were not limited to: a. On 7/18/16, Client #14 hit staff which required the use of the 4 point restraint. The client's activity prior to the behavior identified staff redirected the client from taking other residents special drinks and supplements. Staff restrained both Client #14's feet and right/left wrist. Client #14 started swinging his/her left arm around when staff attempted to restrain his/her left wrist. The restraint form identified Client			

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	#14 remained restrained from 11:30 a.m. to 1:30 p.m., and the first behavior check documented the client had his/her eyes open, on his/her left side incontinent of urine. Staff identified Client #14's behavior at the second and third 15 minute check as eyes open and quiet. The fourth 15 minute check, Client #14 had been quiet, and falling asleep. At the fifth check, Client #14 had been calm and his/her eyes opened when the door first opened. At the 6th check, the client had been calm and quiet. At the 7th check, the client laid on his/her side and briefly opened his/her eyes. When staff removed the restraint at 1:30 p.m., staff documented "soiled (him/herself), got clothes and took shower." b. On 7/11/16, Client #14 attempted to hit staff (took a swing at staff) which required the use of the 4-point restraint. The client's activity prior to the behavior identified he/she had been getting ready [dressed] to go to breakfast and wanted a belt. Staff told the client there wasn't a belt available and staff asked Client #14 to go eat breakfast. The restraint form showed Client #14 remained restrained from 8:48 a.m. to 10:48 a.m., with staff completing 15 minute checks during this time. Staff identified Client #14's behavior at the first 15 minute check as resting, calm lying on the left side. At the 2nd 15 minute check, Client #14 asked "when are you going to get me [up]" and had been calm with his/her eyes open. At the third, fourth, fifth 15 minute checks, Client #14 remained calm with his/her eyes open. At the 6th check, the client stated, "I need help." At the 7th check, the client stated "I need help getting out of these things." c. On 7/14/16, Client #14 attempted to hit staff and was placed in 4-point restraints as a result. The client's activity prior to the behavior identified he/she was prompted by staff to stay awake so he/she slept at night. The restraint form documented Client #14 restrained by 4-points from 10:00			

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	a.m. until 12:00 p.m. The first check noted Client #14 lying on his/her side, quiet with eyes open. The 2nd and 3rd checks noted Client #14 lying quietly on his/her side asleep and waking when the restraints were checked. During the 4th check, Client #14 lay quietly with eyes open and asked to take a shower. The 5th and 6th checks documented Client #14 laid on his/her side and slept, waking when the restraints were checked. The 7th check noted Client #14 laid on his/her side quietly with eyes open. d. On 8/1/16, Client #14 attempted to hit staff and was placed in 4-point restraints as a result. The form documented prior to the behavior, Client #14 asked staff to walk in the courtyard with him/her and was calm. When Client #14 saw another group going to the Life Skills building and found out it wasn't his/her group's turn, he/she walked a little way from life skills, then told staff, "I want you to leave." The form indicated staff responded by coming out with a mat and Client #14 went out the gate and walked away, but eventually walked into the building with a mat around him/her. Initially reluctant, Client #14 complied with 4-point restraint application. Client #14 remained in 4-point restraints from 5:47 p.m. until 7:47 p.m. All seven checks noted Client #14 laid quietly with his/her eyes open. During the 2nd check, Client #14 told staff, "I'm ready to get out." During the 4th check, Client #14 gave a brief, quiet, high-pitched vocalization. e. On 8/9/16, Client #14 slept in bed. Staff prompted Client #14 to go to breakfast, and he/she attempted to hit them, resulting in application of 4-point restraints. The client complied with restraint application. During the first check, the document noted, "on left side, calm, quiet." During the 2nd check, Client #14 told staff, "I don't want to eat breakfast this morning." The 3rd, 4th, 5th, 6th, and 7th checks noted Client #14 laid quietly.			

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	2. Record review on 8/17/16 revealed Client #48's behavior plan to reduce aggression. Restrictive methods included the use of 4-point restraints. The plan stated Client #48 would remain in the 4-point restraints for a maximum of 2 hours, with visual checks every 15 minutes. The program did not include any information regarding when or if Client #48 could be released when calm, prior to the 2 hour maximum. The 4-point restraint had been added to the program on 5/31/16. Review of Client #48's restraint forms from 6/2/16 - 8/14/16 revealed Client #48 utilized 4-point restraints 29 times. All 29 logs indicated Client #48 remained in 4-point restraints for two hours. Many restraint logs noted Client #48 as calm or asleep during 15 minute checks. Examples included, but were not limited to: a. On 7/13/16, Client #48 was placed in 4-point restraints at 4:05 p.m. The restraint form failed to identify the behavior for which the restraint application was necessary. The form also failed to identify the client's activity prior to placement in 4-point restraints. The form documented during the first, second, third, fourth, and fifth checks Client #48 laid quietly. During the sixth check, Client #48 worked to release himself/herself from the restraints. During the seventh check, he/she was redirected back to the restraint. Upon release the resident asked for dinner and was told he/she could only have a Breeze (nutritional supplement), because dinner was over. b. On 6/2/16, Client #48 remained restrained from 6:40 p.m. to 8:40 p.m., with staff completing 15 minute checks during this time. According to the restraint form, at the first check at 6:55 p.m., second check at 7:10 p.m., and third check completed at 7:25 p.m., Client #48 remained quiet			

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	and laid flat on his/her back. At the 4th check, Client #48 stated, "let me out, please" and lifted his/her head up and asked "what are you doing?" There was a small amount of blood on the client's left finger from picking his/her fingernail. Staff notified the nursing staff. At the fifth check, Client#48 sat up in bed and said, "It's not nice to put these on me." During the sixth behavior check at 8:10 p.m., Client #48 laid on his/her back, appeared calm, and also quiet. At 8:25 p.m., the 7th check, the client remained quiet except when he/she asked staff what they were doing. Upon removal of the restraints at 8:40 p.m., Client #48 asked for a snack and sat at the table. c. Also on 6/2/16, at 9:05 p.m., Client #48 took his/her medications and demanded a snack. Staff told him/her no and offered a drink as snack time was over. Client #48 pulled staff's stethoscope around staff's neck and then hit staff. The restraint form showed Client #48 restrained from 9:05 p.m. to 11:05 p.m., with staff completing 15 minute checks during this time. At the first, second, third and fourth 15 minute checks, staff documented Client #48 quiet. At the fifth, sixth and 7th 15 minute check, staff documented Client #48 asleep. When interviewed on 8/17/16 at 10:30 a.m. the PC/QIDP acknowledged Client #48's behavior program for aggression did not provide any criteria for release from the 4-point restraint prior to the 2 hour maximum. She said Client #48 was always put into the 4-point restraint for two hours, regardless of showing signs of being calm. 3. Record review on 8/16/16 revealed Client #2's behavior program to problem solve and decrease aggression, self-injurious behaviors, property destruction and environmental disruption. Methods included use of 4-point restraints. The program directed staff to conduct visual			

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	checks every 15 minutes and to release Client #2 from restraints after 1 hour and 15 minutes if Client #2 was calm and not struggling against the restraints, with a maximum of 2 hour restraint. According to Client #2's Behavior Intervention History, the 4-point restraint was added to his/her behavior program on 5/9/11. The length of time in 4-point restraints was increased to 2 hours on 4/17/13. Review of Client #2's restraint logs revealed Client #2 restrained via 4-points on eight times between 6/7/16 - 8/8/16. During that time, Client #2 twice appeared calm during the 1 hour and 15 minute time period, but was not released. a) Record review on 8/18/16 revealed Client #2's restraint use form dated 7/25/16. The form noted staff placed Client #2 in 4-point restraints at 7:45 p.m. and conducted visual checks every 15 minutes until 9:00 p.m. Documentation of Client #2's behavior at 8:45 p.m. noted "Quiet, not pulling at restraints." Further documentation at 9:00 p.m. read "Quiet" and finally "Released" with no time indicated. b) Review of a restraint use form dated 7/28/16 revealed staff placed Client #2 in 4-point restraints at 4:45 p.m. Staff documentation noted: 5:30 p.m. he/she rested on his/her side, quiet and "playing" with straps; 5:45 p.m. "had nails clipped" and apologized to staff; 6:00 p.m. calm, and final documentation stated "out" with no time noted. When interviewed on 8/18/17 at 9:55 a.m., the Program Coordinator/Qualified Intellectual Disability Professional (PC/QIDP) stated Client #2 remained in 4-point restraints			

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	for 1 hour and 15 minutes regardless of when he/she calmed and/or ceased maladaptive behavior(s). 4. Observation on 8/15/16 at 3:05 p.m. revealed Client #12 received two 1 milligram tablets of Lorazepam. Record review on 8/16/16 revealed a physician's order for Lorazepam to be given prior to dental/medical/dermatology procedures. Further record review on 8/17/16 revealed Client #12's Nursing Care Plan. The plan noted Client #12 experienced anxiety and resultant behaviors related to medical procedures. The care plan failed to identify specific behaviors associated with Client #12's anxiety, failed to include positive teaching strategies to teach Client #12 to decrease his/her anxiety, and lacked any criteria to reduce the need for use of Lorazepam. When interviewed on 8/18/16 at 1:00 p.m. the Registered Nurse (RN)/Director of Nursing (DON)/Qualified Intellectual Disability Professional (QIDP) confirmed the care plan lacked the information noted. 5. Record review on 8/17/16 revealed Client #31's guardian written informed consent for the reduction of Self-Injurious Behavior (SIB); verbal consent was obtained on 3/17/16 and written consent obtained on 7/20/16. The consent identified prn (as needed) medication was discontinued; the consent failed to identify any other restrictive measures utilized in conjunction with his/her behavior program to reduce SIB. Additional record review of Interdisciplinary Progress Notes revealed on 5/4/16 the facility sent a facsimile (fax)			

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	to Client #31's Primary Care Physician (PCP) requesting an increase in his/her Vistaril due to the size of the wound on his/her chin increasing; the PCP returned the fax and declined increasing the dose. It was noted Client #31's psychiatrist would be contacted because "its related to behaviors." A fax to the psychiatrist on 5/4/16 reported,"res. had an (increase) in SIB (picking at chin). The area on (his/her) chin is quite big and deep. Currently (he/she) is on Vistaril 50 mg (milligrams) qd (daily). May we have an order to (increase) dosage?" On 5/12/16, the doctor responded to increase the dosage to 100 mg three times per day. Another fax was sent to his/her psychiatrist on 7/29/16 informing the doctor Client #31 had an increase in SIB, wound size, and aggression. On 8/15/16, Client #31 was seen by his/her psychiatrist and his/her Vistaril was increased to 100 mg four times daily. Review of Client #31's medication history documented the reason for the use of Vistaril on 5/12/16 was due to rash/picking; on 8/15/16 it was noted it was due to behaviors. When interviewed on 8/17/16, at 2:10 p.m., PC/QIDP acknowledged Vistaril was not included in Client #31's guardian written informed consent and was not identified as being utilized in conjunction with Client #31's behavior program. The PC/QIDP stated she was not aware of a facility policy regarding obtaining Informed Consents but stated they follow the regulations regarding written informed consent for the use of restrictive measures. 6. Record review on 8/17/16 revealed Client #35's Individual Program Plan (IPP) to sleep at night without disruption. The program noted use of the medication			

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	Trazodone. Further review revealed an informed consent form signed by the guardian on 2/16/15. Additional review revealed an agency form which indicated Client #35's guardian gave verbal consent for the use of Trazodone on 2/29/16. No documentation of written consent for use of Trazodone since 2/16/15 could be located. When interviewed on 8/17/16 at 1:45 p.m., PC/QIDP confirmed a consent form was mailed to the guardian who failed to sign and return the form. She noted a new consent had been sent to the guardian for her signature on 8/17/16. 7. Record review on 8/17/16 revealed Client #41's Medication Intervention consent. The consent noted use of Ativan (Lorazepam) for anxiety. Further review revealed a Nursing Care Plan noted Client #41 experienced anxiety as evidenced by restlessness, jumpiness, inability to relax, frequent urination, difficulty concentrating and impatience. The care plan failed to include strategies to teach Client #41 coping skills to decrease his/her anxiety. The care plan further lacked criteria to reduce the need for use of Lorazepam. When interviewed on 8/18/16 at approximately 1:03 p.m., the RN/DON/QIDP confirmed the program lacked teaching strategies and criteria for medication reduction. Record review on 9/6/16 revealed the facility's policy titled, "Enhancing and Maintaining Quality of Life." The policy included, "Staff will focus on treating each with dignity and respect in full recognition of his or her individuality as they carry out activities that assist the resident to maintain or enhance his/her self-esteem and self-worth... The facility			

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	will provide reasonable accommodations of residents' individual needs and preferences related to their care and environment, directed toward assisting the resident to maintain and/or achieve their highest practicable level of functioning, promoting dignity and well-being, except when the health and safety of the individual or other residents would be endangered." **FACILITY RESONSE**			

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64.60	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.** **Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.** **This rule is intended to implement Iowa Code Section 135C.2(3).**	II	$500.00	UPON RECEIPT
W274	**483.450(b)(1) MANAGEMENT OF INAPPROPRIATE CLIENT BEHAVIOR** The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior. **DESCRIPTION:** Based on interview and record review, the facility failed to ensure behavior management interventions were implemented in accordance with approved facility policy. This affected 1 of 1 client whose individual program plan included the use of time-out room (Client #48). Finding follows: 1. Record review on 8/17/18 revealed Client #48 had a behavior program for emotional control. The objective of the program indicated the client would not need to be helped to the quiet area more than five times for two			

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	consecutive months. The program stated if Client #48 became aggressive, staff should use mats to assist Client #48 to the calm room. The program further stated, "Once in the calm room staff may exit and sit outside the room. If (Client #48) attempts to leave before 15 minutes, (he/she) will be reminded to finish (his/her) calm down time. (He/she) may remain in the calm area no more than 2 hours, but may come out after fifteen minutes or as soon as (he/she) is calm after 15 minutes." Record review on 8/17/18 revealed a written informed consent for Client #48's emotional control program. The consent stated, "Staff will keep the door closed to the room so others do not see the behavior and to give (Client #48) less to stimulate from. Time in the calm room will be a minimum of 15 minutes with a ceiling of 2 hours. If (Client #48) attempts to leave the room before 15 minutes is up, staff will remind (him/her) to remain a bit longer. Staff will remain outside the door, listening for movements, statements, etc." When interviewed on 8/17/16 at 12:00 p.m. DA B said staff shut the door when Client #48 went into the Calm Room and then staff stood outside of the door. When interviewed on 8/17/16 at 12:05 p.m. the Prevocational Coordinator (PVC)/QIDP confirmed staff shut the door and prevented Client #48 from leaving the Calm Room until the client was calm for 15 minutes. 2. Record review revealed Client #2's individual program plan to address prevocational behavior, with an goal to not need removed from an area of the center. Methods of the program directed if Client #2 engaged in maladaptive behaviors (including but not limited to: hitting or kicking			

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	others, biting, scratching others, and throwing objects), attempted to aggress towards others, engaged in self-injurious behavior, property destruction, or environmental hazard, he/she would be moved to another room. The program directed staff to utilize a mat as a barrier to assist with moving the client to the room. After 1 hour and 15 minutes, Client #2 could leave the room if calm and no longer showing signs of maladaptive behavior. The client could stay in the room no longer than two hours. The program directed staff to leave the room one by one and stand outside the door, which should be closed. Record review of facility policy "Hierarchy of Behavioral Interventions," last revised 6/17/16, revealed time-out was not identified as an approved intervention the facility utilized. The policy identified the use of Supervised Room Separation which was defined as "Individual is taken to their room or other calm area for a supervised calm down time. Staff must remain present, and time in room must have a ceiling of allowed time, with calm criteria listed." **FACILITY RESPONSE :**			

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64.60	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.** **Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.** **This rule is intended to implement Iowa Code Section 135C.2(3).**	II	$500.00	Upon Receipt
W 285	**483.450(b)(2) MANAGEMNT OF INAPPRIOPATE CLIENT BEHAVIOR** **Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.** **DECRIPTION:** Based on observation, interviews and record reviews, the facility failed to ensure interventions used to manage client behaviors were implemented with sufficient safeguards to protect client welfare and civil and human rights. This affected 3 of 3 clients for whom 4-point restraints and/or time-out rooms were used (Client #2, Client #14 and Client #48). Findings follow: 1. See W302 for additional information. Record review on 8/17/16 and 8/18/16 revealed the			

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Administrator Date

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Number FC 6284		Report Date October 7, 2016
Facility Name Harmony House Health Care Center	Fine amount reduced to $3,250.00 On December 6, 2016 pursuant to Iowa Code Section 135C.43A	Survey Dates August 15-22, 2016 & September 6, 2016
Facility Address 2950 West Shaulis Road		Survey
City Waterloo, IA 50701	HL/CC	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
	following: a. Client #14's behavior program directed the client place in 4-point restraints for acts of aggression for a minimum of 2 hours, regardless of when he/she showed signs of being calm. Client #14's behavior program indicated he/she would be "consequated with the immediate application of 4 pt. restraints to (his/her) wrists and ankles for a 2 hr. period following QIDP authorization." b. Client #48's behavior program directed the client placed in 4-point restraints for acts of aggression for a minimum of two hours, regardless of when he/she showed signs of being calm. c. Client #2's behavior program for aggression directed Client #2 placed in 4-point restraints for aggression for a minimum of 1 hour and 15 minutes, regardless of when Client #2 calmed down. 2. See W291 and W293 for additional details. a. Record review on 8/17/16 and 8/18/16 revealed Client #48's behavior program for emotional control indicated staff could assist the client to the calm room. The program further directed, once in the calm room, the door was shut and staff sat outside of the door. Client #48 was not allowed to leave the calm room until calm for 15 minutes. Observations on 8/17/16 revealed the calm room failed to meet the criteria for a time-out room. The door failed to include required safeguards, including: methods to ensure constant visual supervision of the client and protection from hazardous conditions. The room included uncovered			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
	electrical outlets, plaster or sheet rock walls, and overhead light fixtures with a thin plastic covering. When interviewed on 8/17/16 at 12:05 p.m. the Prevocational Coordinator (PVC)/QIDP confirmed staff shut the door and prevented Client #48 from leaving the Calm Room until the client was calm for 15 minutes. b. Record review revealed Client #2's individual program plan to address prevocational behavior, with an goal to not need removed from an area of the center. Methods of the program directed if Client #2 engaged in maladaptive behaviors (including but not limited to: hitting or kicking others, biting, scratching others, and throwing objects), attempted to aggress towards others, engaged in self-injurious behavior, property destruction, or environmental hazard, he/she would be moved to another room. The program directed staff to utilize a mat as a barrier to assist with moving the client to the room. After 1 hour and 15 minutes, Client #2 could leave the room if calm and no longer showing signs of maladaptive behavior. The client could stay in the room no longer than two hours. The program directed staff to leave the room one by one and stand outside the door, which should be closed. Observations on 8/17/16 revealed the calm room failed to meet the criteria for a time-out room. The door failed to include required safeguards, including: methods to ensure constant visual supervision of the client and protection from hazardous conditions. The room included uncovered electrical outlets, plaster or sheet rock walls, and overhead light fixtures with a thin plastic covering. **FACILITY RESPONSE:**			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
64.40	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.** **Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.** **This rule is intended to implement Iowa Code Section 135C.2(3).**	II	$500.00	Upon Receipt
W291	**483.450(c)(1) TIME OUT ROOMS** **A client may be placed in a room from which egress is prevented only if the following conditions are met:** **(i) The placement is a part of an approved systematic time-out program as required by paragraph (b) of this section. (Thus, emergency placement of a client into a time-out room is not allowed.)** **(ii) The client is under the direct constant visual supervision of designated staff.** **(iii) The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.** **DESCRIPTION:** Based on interviews and record reviews, the facility failed to ensure interventions utilized meeting the definition of time out room maintained all necessary conditions. This affected 2 of 2 sample clients client whose individual program plan included the use of time-out room (Client #2			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
	and #48). Finding follows: 1. Record review revealed Client #2's individual program plan to address prevocational behavior, with an goal to not need removed from an area of the center. Methods of the program directed if Client #2 engaged in maladaptive behaviors (including but not limited to: hitting or kicking others, biting, scratching others, and throwing objects), attempted to aggress towards others, engaged in self-injurious behavior, property destruction, or environmental hazard, he/she would be moved to another room. The program directed staff to utilize a mat as a barrier to assist with moving the client to the room. After 1 hour and 15 minutes, Client #2 could leave the room if calm and no longer showing signs of maladaptive behavior. The client could stay in the room no longer than two hours. The program directed staff to leave the room one by one and stand outside the door, which should be closed. 2. Record review on 8/17/18 revealed Client #48's behavior program for emotional control. The objective of the program indicated the client would not need to be helped to the quiet area more than five times for two consecutive months. The program stated if Client #48 became aggressive, staff should use mats to assist Client #48 to the calm room. The program further stated, "Once in the calm room staff may exit and sit outside the room. If (Client #48) attempts to leave before 15 minutes, (he/she) will be reminded to finish (his/her) calm down time. (He/she) may remain in the calm area no more than 2 hours, but may come out after fifteen minutes or as soon as (he/she) is calm after 15 minutes." Record review on 8/17/18 revealed a written informed			

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	consent for Client #48's emotional control program. The consent stated, "Staff will keep the door closed to the room so others do not see the behavior and to give (Client #48) less to stimulate from. Time in the calm room will be a minimum of 15 minutes with a ceiling of 2 hours. If (Client #48) attempts to leave the room before 15 minutes is up, staff will remind (him/her) to remain a bit longer. Staff will remain outside the door, listening for movements, statements, etc." When interviewed on 8/17/16 at 12:00 p.m. DA B said staff shut the door when Client #48 went into the Calm Room and then staff stood outside of the door. When interviewed on 8/17/16 at 12:05 p.m. the Prevocational Coordinator (PVC)/QIDP confirmed staff shut the door and prevented Client #48 from leaving the Calm Room until the client was calm for 15 minutes. Observation of the Calm Room on 8/17/16 at 12:10 p.m. revealed the Calm Room had a wooden door with no window or peep hole. When the door was closed it was not possible to see into the Calm Room. (See W293 for additional information.) Record review on 8/18/16 revealed Client #48's restraint logs for time in the Calm Room. The restrained logs showed Client #48 had been in the Calm Room 12 times from 6/23/16 to 8/11/16. The restraint logs revealed Client #48 was released from the Calm Room when discovered to be calm during one of the 15 minute checks. The amount of time spent in the Calm Room ranged from 15 minuets to 1 hour and 15 minutes, with an average			

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	amount of time of 30 minutes. **FACILITY RESOPNSE:**			

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64.60	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.** **Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.** **This rule is intended to implement Iowa Code Section 135C.2(3).**	II	$500. 00	Upon Reciept
W 293	**483.450(2)(3) TIME OUT ROOMS** **Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.** **DESCRIPTION:** Based on observations, the facility failed to ensure areas utilized for behavior interventions meeting the definition of time out room provided adequate conditions to ensure client safety. This affected 2 of 2 sample clients whose individual program plan included the use of time-out room (Client #2 and #48). Finding follows: 1. Record review revealed Client #2's individual program plan to address prevocational behavior, with an goal to not need removed from an area of the center. Methods of the program directed if Client #2 engaged in maladaptive			

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	behaviors (including but not limited to: hitting or kicking others, biting, scratching others, and throwing objects), attempted to aggress towards others, engaged in self-injurious behavior, property destruction, or environmental hazard, he/she would be moved to another room. The program directed staff to utilize a mat as a barrier to assist with moving the client to the room. After 1 hour and 15 minutes, Client #2 could leave the room if calm and no longer showing signs of maladaptive behavior. The client could stay in the room no longer than two hours. The program directed staff to leave the room one by one and stand outside the door, which should be closed. 2. Record review on 8/17/18 revealed Client #48 had a behavior program for emotional control. The objective of the program was that the client would not need to be helped to the quiet area more than five times for two consecutive months. The program stated if Client #48 became aggressive, staff should use mats to assist Client #48 to the calm room. The program further stated, "Once in the calm room staff may exit and sit outside the room. If (Client #48) attempts to leave before 15 minutes, (he/she) will be reminded to finish (his/her) calm down time. (He/she) may remain in the calm area no more than 2 hours, but may come out after fifteen minutes or as soon as (he/she) is calm after 15 minutes." Record review on 8/17/18 revealed a written informed consent for Client #48's emotional control program. The consent stated, "Staff will keep the door closed to the room so others do not see the behavior and to give (Client #48) less to stimulate from. Time in the calm room will be a minimum of 15 minutes with a ceiling of 2 hours. If			

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	(Client #48) attempts to leave the room before 15 minutes is up, staff will remind (him/her) to remain a bit longer. Staff will remain outside the door, listening for movements, statements, etc." When interviewed on 8/17/16 at 12:00 p.m. DA B said staff shut the door when Client #48 went into the Calm Room and then staff stood outside the door. When interviewed on 8/17/16 at 12:05 p.m. the Prevocational Coordinator (PVC)/QIDP confirmed staff shut the door and prevented Client #48 from leaving the Calm Room until the client was calm for 15 minutes. Observation of the Calm Room on 8/17/16 at 12:10 p.m. revealed the Calm Room had a wooden door with no window or peep hole. When the door was closed it was not possible to see into the Calm Room. The size of the room was approximately 14 feet by 9 feet. The walls were plaster or sheet rock. The floor had a thin carpet. Two sets of fluorescent lights were on the ceiling with thin plastic coverings. An uncovered electrical outlet was on one wall. Two small tables and three chairs were also in the room. There was a hole in one of the walls, about the size of a fist, and one of the staff stated Client #48 had punched the hole in the wall. Staff was present at the time of the incident. **FACILITY RESPONSE:**			

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W 295	**483.450(d)(1)(i) PHYSICAL RESTRAINS** **The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.** **DESCRIPTION:** Based on record review, the facility failed to ensure the implementation of restrictive measures wholly integrated into the individual program plan (IPP). The facility failed to ensure individual program plans included a hierarchy of behavior management measures utilized prior to the application of physical restraints. Additionally, the facility failed to identify and include client behavior to indicate the client is calm and can be released from restraints. Finally, the IPP failed to provide appropriate replacement behavior taught to clients to reduce the need for future restraints. This affected 3 of 3 clients (Client #2, #14, and #48) whose IPP included the use of 4 point restraints.			

If, within thirty (30) days of the receipt of the citation, you: (1) do not request a formal hearing or; (2) withdraw your request for formal hearing; and (3) pay the penalty, the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2015).

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	Findings follow: 1. Record review on 8/18/16 revealed Client #14's program to address reduction of aggression, initiated 7/8/16. The program defined aggression as hitting, kicking, pushing others, hitting others with objects, throwing objects toward others, pulling hair, biting or other aggressive acts with the intention of causing harm to others. Attempted aggression was defined as: attempting to engage in any act or combination of acts of aggression that without staff intervention, aggression would occur. According to the program, if staff observed Client #14 become upset without aggressing and/or attempting to aggress, they should ask what bothers him/her and attempt to correct it, if possible. Client #14 should be offered a break. Additional record review revealed Client #14's restraint forms since 6/15/16 included, but were not limited to the following incidents: a. On 7/11/16, Client #14 attempted to hit staff (took a swing at staff) and was placed in 4-point restraints as a result. The client's activity prior to the behavior identified he/she had been getting ready [dressed] to go to breakfast and wanted a belt. Staff told the client there wasn't a belt available and staff asked Client #14 to go eat breakfast. The restraint form showed Client #14 remained restrained from 8:48 a.m. to 10:48 a.m., with staff completing 15 minute checks during this time. c. On 7/14/16, Client #14 attempted to hit staff and was placed in 4-point restraints as a result. The client's activity prior to the behavior identified he/she was prompted by staff to stay awake so he/she slept at night. The restraint form documented Client #14 restrained by 4-points from 10:00			

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	a.m. until 12:00 p.m. d. On 8/1/16, Client #14 attempted to hit staff and was placed in 4-point restraints as a result. The form documented prior to the behavior, Client #14 asked staff to walk in the courtyard with him/her and was calm. When Client #14 saw another group going to the Life Skills building and found out it wasn't his/her group's turn, he/she walked a little way from life skills, then told staff, "I want you to leave." The form indicated staff responded by coming out with a mat and Client #14 went out the gate and walked away, but eventually walked into the building with a mat around him/her. Initially reluctant, Client #14 complied with 4-point restraint application. Client #14 remained 4-point restraints from 5:47 p.m. until 7:47 p.m. f. On 8/9/16, Client #14 slept in bed. Staff prompted Client #14 to go to breakfast, and he/she attempted to hit them, resulting in application of 4-point restraints. Client #14 remained in restraints from 8:35 a.m. to 10:35 a.m. g. On 7/8/16, staff prompted Client #14 to stay awake. Client #14 was incontinent and prompted to change his/her wet clothes. Client #14 was prompted to change his/her shirt and wanted to keep the same shirt on. Client #14 attempted to hit staff. Client #14 was placed in 4-point restraints, and remained from 10:33 a.m. to 12:33 a.m. Further review of the program revealed on third shift, when Client #14 engaged in aggression and/or attempted aggression, staff should ask him/her what was wrong and correct it if possible. The program directed staff to block any further aggression/attempted aggression with mats and/or blocking boards; unless they were unavailable at which time staff would utilized a Mandt hold (up to three minutes) until blocking boards and mats are available.			

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	The program further directed on first and second shift, if Client #14 aggressed or attempted to aggress, he/she would be "consequated with the immediate application of 4-point restraints." The program failed to provide a hierarchy of least restrictive measures to be used prior to application of restraints. Additional review revealed once in 4-point restraints, Client #14 would remain for a two hour period. The program failed to identify client behavior to indicate he/she was calm and could be released from the restraint. Further review of the program revealed the program exclusively provided methods to address Client #14's aggressive/attempted aggressive behavior. The program lacked teaching of an appropriate replacement behavior for aggression. 2. Record review on 8/17/16 revealed Client #48's program to discuss problems with staff and peers, initiated 7/21/16. The program served to address aggression and self-injurious behavior. The program defined self-injurious behavior as picking at self, scratching self, and hitting head on objects or with hand. Aggression was defined as engaging in one or more of the following: hitting, kicking, shoving, biting, scratching, hair pulling, throwing objects, pushing objects into others or grabbing others. Attempted aggression was defined as attempts to engage in defined aggression that without staff intervention would result in the occurrence of aggression. The program defined precursor behaviors as becoming verbally unresponsive, using rigid posture, refusing redirection, entering areas he/she should not, planting himself/herself in areas he/she is not scheduled in, staring firm and fixed on the person he/she is upset with, screaming out/crying, clenching fists, and grabbing items not belonging to him/her. The program directed staff to			

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	redirect Client #48, set limits, and attempt to problem solve when he/she exhibited precursor behaviors. The program directed the application of 4-point restraints upon first incident of aggression or attempted aggression. The program failed to provide a hierarchy of least restrictive measures to be used prior to application of restraints. Additional review of the program revealed once in 4-point restraints, Client #48 would remain for two hours. The program failed to identify behavior to indicate he/she was calm and could be released from restraint. Further review of the program revealed the program exclusively provided methods to address Client #48's inappropriate behavior. The program lacked teaching of an appropriate replacement behavior for Client #48. 3. Record review on 8/16/16 revealed Client #2's behavior program to address maladaptive behaviors, initiated 7/13/16. Behaviors identified included, but were not limited to: hitting, kicking, biting, scratching, throwing objects, hitting with objects, swinging objects at others, pulling others' hair, grabbing others, or using his/her body in any way to force himself/herself past staff or injure staff. The program also included attempted aggression, self-injurious behavior, property destruction, and environmental disruption. The program also identified precursor behaviors, which included: talking rapidly while having difficulty finding words, closing/covering ears, closing/covering eyes, fist or fists clenched while shaking arms, change in facial expression, and picking skin on his/her arms. When exhibiting precursor behaviors, the program directed staff to talk to Client #2 and correct what bothered him/her if possible, offer a break, or engage in other activities to calm down. Calm was defined as no longer engaging in two or more precursor behaviors.			

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Administrator Date

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Number FC 6284		Report Date October 7, 2016
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	The program further directed the application of 4-point restraints upon first incident of engaging in maladaptive coping methods. The program failed to provide a hierarchy of least restrictive measures to be used prior to application of restraints. Additional review of the program revealed the program exclusively provided methods to address Client #2's aggressive/attempted aggressive behavior. The program lacked teaching of an appropriate replacement behavior for aggression. **FACILTY RESPONSE:**			

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50.(7) 4	**481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:** **50.7(4) When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff.** **DESCRIPTION** Based on interviews and record reviews, the facility failed to report all incidents of client elopement, in accordance with state rules. This affected 1 of 1 sample client with a recent elopement (Client #48). Finding follows: Record review on 8/15/16 of facility incident reports from 5/15/16 through 8/15/16 revealed no incident reports related to elopement. When interviewed on 8/17/16 at 10:30 a.m. Qualified Intellectual Disability Professional (QIDP) A stated Client #48's WanderGuard bracelet had been discontinued in late July 2016, but had been re-implemented on 8/08/16 after three incidents within a week of Client #48 going out the exit doors. QIDP A could not locate additional documentation regarding these three incidents. During a follow-up interview on 8/17/16 at 2:35 p.m. QIDP A stated during two of the incidents she thought staff saw Client #48 leave and staff pursued the client and brought him/her back to the facility. QIDP A stated on one occasion Client #48 left without staff knowledge and was found outside,	II	$500.00	Upon Receipt

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	near another agency building. When interviewed on 8/17/16 at 3:15 p.m. the Program Coordinator/QIDP (PC/QIDP) confirmed Client #48 left the building without staff knowledge on 8/07/16. The PC/QIDP said she conducted an investigation and she had the incident report, which she shared with the surveyor. The PC/QIDP said she estimated Client #48 gone from the facility without staff supervision for approximately 15 minutes. The PC/QIDP said the incident was reported to the agency administrator. It was not reported to the Department of Inspections and Appeals (DIA), because Client #48 had not left facility property. Review of the facility investigation revealed a Quality Assurance Investigation form, which stated the incident occurred 8/07/16 at approximately 4:00 p.m. and resulted in no injuries. Developmental Assistant (DA) A said she saw Client #48 at approximately 3:45 p.m. when the client had juice in the lounge area. Recreation Assistant (RA) A said she was driving back to the facility from at outing at 4:00 p.m. when she saw Client #48 walking on the sidewalk in front of the Danbury building, walking away from the main Harmony House building. Client #48 agreed to get into the vehicle and rode back to the main building with RA A. Observation on 8/18/16 revealed the Danbury building on the agency property approximately ½ block from the main Harmony House building. The Danbury building sat outside of the fenced in area of Harmony House, with a two lane residential road a few feet from the sidewalk in front of the building.			

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	Record review on 8/17/16 revealed Client #48 was 20 years old with a diagnosis including moderate to severe intellectual disability, Down Syndrome, mood disorder, hearing loss and vision loss. Client #48 had hearing aids and eye glasses prescribed, but typically refused to wear them. Client #48 ambulated independently and had functional verbal communication. Client #48 had a program in place to Remain in Authorized Area Unless Supervised. The program stated, "For (Client #48's) safety and the safety of others due to (his/her) history and present behaviors of SIB (self-injurious behavior) and aggression toward others it is in the best interest of (Client #48) that staff are aware of (his/her) whereabouts. (Client #48) has also been struggling to make safe choices therefore putting (him/her) at risk if (he/she) is not properly supervised." The program further stated Client #48 should not leave the unit without staff accompanying him/her and staff should always be aware of Client #48's location on and off the unit. According to the state climatologist, the weather conditions in the Waterloo area on 8/07/16 at 3:54 p.m. were 77 degrees Fahrenheit with no precipitation. The facility administrator provided a written statement dated 8/07/16, which stated she had been notified at 4:15 p.m. that Client #48 left the building, wanting to go home (parental home). The administrator stated Client #48 was found on facility property, it was daylight and the weather was warm and sunny. Client #48 dressed appropriately for the weather. The facility reinstated Client #48's WanderGuard after this incident.			

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	When interviewed on 8/18/16 at 11:30 a.m., the Administrator confirmed she had not reported the elopement because Client #48 did not leave facility property. **FACILITY RESPONSE:**			

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