STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G009	A. BUILDING _____ B. WING _____	C 11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE HEALTH CENTER	2950 WEST SHAULIS ROAD WATERLOO, IA 50701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS As a result of investigation #64290-I, standard level deficiencies were cited at W104 and W249.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, facility staff failed to consistently follow facility policies, as evidenced by failure to ensure exit door alarms were activated at all times. This affected 1 of 1 client (Client #1) involved in investigation #64290-I. Finding follows: Record review on 11/17/16 revealed facility internal investigation, initiated 11/6/16. The investigation identified Client #1 had eloped from the Opportunity Advancement Center (OAC) through the East door on 11/6/16 at approximately 1:14 p.m. Prevocational Aid (PA) A located Client #1 approximately 1 and ½ blocks away from the facility and they returned at approximately 1:32 p.m. The investigation identified the door alarm was not activated at the time of the elopement. The document noted Client #1 had watched staff remove the batteries from the alarm to go outside and prevent disruption to other clients present at OAC. Additional record review on 11/21/16 revealed Client #1 was diagnosed with, but not limited to, unspecified intellectual disabilities, down syndrome (unspecified), unspecified mood disorder, sleep disorder, bilateral sensorineural	W 104	See attached POC 11/15/16	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 hearing loss, unspecified visual loss, and conversion disorder with sensory symptom or deficit. Client #1 had programming in place to increase emotional control, reduce aggressive behavior by discussing problems with staff, increase sleep without disturbance, remaining in authorized areas unless supervised, earning reinforcers for participation in an activity, following a schedule, reading comprehension, , and participation in medication administration. Restrictive measures included the use of a wander guard bracelet (alarms on 3 doors on the living unit), a bedroom door alarm, physical restraint, 4-point restraints, and behavior modifying medications which included Depakote, Lithium Carbonate, Geodon, and Effexor. Staff were instructed to complete 15 minute visual checks on Client #1 and to know his/her whereabouts at all times. When interviewed on 11/21/16 at approximately 11:35 a.m., Program Assistant (PrA) B reported she had been in one of the classrooms at the OAC when PA A and Client #1 returned inside at approximately 1:15 p.m. PrA B stated she looked out of the room to answer a question and observed Client #1 standing inside the building, close to the East exit door. PrA B stated a few minutes later, PA A approached her and asked where Client #1 was at. At this time, a search was initiated and Client #1 was found walking East down the sidewalk approximately 1 and ½ blocks away from the facility. PrA B stated she did not hear the exit door alarm sound when PA A and Client #1 entered through the East door or when Client #1 exited the building through the East Door. Additional record review on 11/21/16 revealed	W 104		

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W 104	Continued From page 2 End of Day Protocols for Pre-Vocational Center. The list included checking all exit door alarms. On 11/5/16 and 11/6/16, the checklist was completed by PrA B which indicated all alarms were in working order. When interviewed on 11/22/16 at approximately 8:45 a.m., PA A reported she and Client #1 had been outside the OAC doing an activity with spray paint. She stated they walked back inside to wash their hands and thought she had shut the door behind her but stated it was a windy day. PA A stated she reported Client #1 over to another staff but didn't know he had headphones on and was unable to hear her. After she washed her hands, she stated she realized Client #1 was not present and a search for Client #1 was initiated. PA A stated Client #1 was going East on the sidewalk, she utilized her personal car and picked up Client #1 approximately 1 and ½ blocks away from the facility. PA A reported Client #1 said he/she wanted to go home but got lost when PA A asked why he/she left without telling staff. PA A reported the all exit doors at the OAC had alarms but couldn't recall the alarm sounding on 11/6/16 when using the East door. She stated the battery cover to the alarm had been lost and the batteries would fall out if the door was shut hard. PA A stated this was reported but never fixed so staff continued to check the door alarms. When interviewed on 11/22/16 at approximately 11:15 a.m., the Qualified Intellectual Disability Professional/Vocational Specialist (QIDP/VS) reported Client #1 had a history of attempting to leave the OAC to go back to the facility without telling staff. She stated this behavior had decreased but recently they noticed an increase of Client #1 attempting to leave through the North	W 104		

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W 104	Continued From page 3 door to return to the facility without telling staff. QIDP/VS stated staff would assist him/her to return to OAC or the living unit depending on what Client #1 wanted to do. QIDP/VS stated on 11/4/16 alarms on all doors were in place and working prior to her shift ending. She stated the end of day checklist for 11/5/16 and 11/6/16 indicated the alarms were all in place and working. QIDP/VS stated even without a battery cover on the alarm, the batteries securely fit and only came out if the door was slammed. She explained to reset the alarm the batteries had to be removed. She reported on 11/7/16 new alarms were installed on the West and East doors which were hard-wired and could only be reset by entering a code. Review of facility policy "Elopement Prevention Program", last revised 6/9/14, instructed alarms would be activated on all exit doors if the client population included one or more clients at-risk for elopement. When interviewed on 11/22/16 at approximately 12:10 p.m., the Administrator confirmed staff failed to follow the facility policy by not ensuring exit door alarms were on and active at all times. She stated it is unclear if the alarm was up with the batteries removed or if the staff had left the alarm down when Client #1 eloped from the OAC.	W 104		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 4 objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, facility staff failed to consistently implement client Behavior Support Plans, specifically in regards to client supervision needs. This affected 1 of 1 client (Client #1) involved in investigation #64290-I. Finding follows: Record review on 11/17/16 revealed facility internal investigation, initiated 11/6/16. The investigation identified Client #1 had eloped from the Opportunity Advancement Center (OAC) through the East door on 11/6/16 at approximately 1:14 p.m. The investigation noted prior to Client #1 eloping, Prevocational Aid (PA) A and Client #1 had gone outside through the East door to complete an activity. PA A re-entered the building and Client #1 was behind her. PA A never checked to ensure Client #1 entered the building or to ensure the door was closed. PA A walked to the wash bay area while Client #1 stood briefly by the East exit door and then left through the open East door. A search was initiated and Client #1 was located approximately 1 and ½ blocks away from the facility. Client #1 returned to the OAC at approximately 1:32 p.m. with PA A. Additional record review on 11/21/16 revealed Client #1 was diagnosed with, but not limited to, unspecified intellectual disabilities, down syndrome (unspecified), unspecified mood disorder, sleep disorder, bilateral sensorineural hearing loss, unspecified visual loss, and	W 249		

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W 249	Continued From page 5 conversion disorder with sensory symptom or deficit. Client #1 had programming in place to increase emotional control, reduce aggressive behavior by discussing problems with staff and peers, increase sleep without disturbance, remaining in authorized areas unless supervised, earning reinforcers for participation in an activity, following a schedule, reading comprehension, and participation in medication administration. Restrictive measures included the use of a wander guard bracelet (alarms on 3 doors on the living unit), a bedroom door alarm, physical restraint, 4-point restraints, and behavior modifying medications which included Depakote, Lithium Carbonate, Geodon, and Effexor. Review of Client #1's programming revealed his/her Behavior Support Plan titled "Discuss Problems with Staff and Peers", last revised 8/25/16. The program instructed staff to always be aware of Client #1's whereabouts and to document 15 minute observations of Client #1. Continued review revealed Client #1's Behavior Support Plan titled "Remain in Authorized Areas Unless Supervised", last revised 11/15/16. The program instructed staff to always be aware of Client #1's location on and off the unit. When interviewed on 11/21/16 at approximately 3:15 p.m., Client #1 stated "I did it on my own" but would not discuss the incident any further. When interviewed on 11/22/16 at approximately 8:45 a.m., PA A reported on the afternoon of 11/6/16 she had gone outside, using the East door at the OAC, with Client #1 to do an activity. PA A stated once they returned inside the building she asked another staff to watch Client #1 but	W 249		

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W 249	Continued From page 6 was unaware the other staff had headphones on and couldn't hear her. PA A stated after she finished washing her hands she realized Client #1 was not present and a search was initiated. PA A stated Client #1 was observed walking East down the sidewalk so she utilized her personal vehicle to transport Client #1 back to the facility. PA A confirmed Client #1 had crossed one street and was approximately 1 and 1/2 blocks away from the facility when located. PA A confirmed she was aware Client #1 was to have 15 minutes checks and staff were to know his/her whereabouts at all times. When interviewed on 11/22/16 at approximately 12:10 p.m., the Administrator confirmed staff failed to follow Client #1's Behavior Support Plan by not knowing his/her whereabouts at all times. She stated according to the video recording, PA A entered the building and Client #1 followed. She stated the video revealed PA A never turned around and checked to ensure Client #1 had entered the building or to ensure the door was closed.	W 249		

√ LK 1/3/17

CAC 12/30/16

December 29, 2016

Plan of Correction related to Harmony House Health Center self-report #44531 occurring on 11/06/2016.

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under federal or state law.

F000 correction date: 12/20/16
W104 483.410(a)(1) GOVERING BODY
The governing must exercise general policy, budget, and operating direction over the facility.
The governing body does exercise general policy, budget, and operating direction over the facility.

1. Daily alarm checks are performed on alarmed doors in the ICF/ID unit and Pre-vocational unit and this will continue to be our practice.
2. The staff were educated regarding the need for monitoring and the safety of clients as well as elopement prevention policy and procedures on 11/06/2016.
3. On 11/7/2016, 7:30am the alarm was changed on the East door. The new alarm is electrically wired which will automatically alarm when the door is opened and will not silence until staff reset the alarm.
4. Alarm activation is audited every 2 hours, by staff and reviewed daily by the coordinator. Data will be assembled and reviewed through the QA process.

W249 483.440(d)(1)Program Implementation
As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consistent of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

Each client has a continuous active treatment program, consistent of needed interventions and services in sufficient number and frequency to support the achievement of the objective identified in the individual program plan.

1. The staff were re-educated on 11/06/2016, of the need for monitoring and the safety of clients, as described in the program plan.
2. The individual program plan was updated on 11/15/2016 to reflect the new, more restrictive status of client #1
3. Each individual program plan is updated as circumstance changes and goals are met.
4. Programs are updated for each client based on goal achievement and/or incident impacting the needs of the client