✓ 6/14/18

PRINTED: 05/30/2018
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070811	A. BUILDING: _____ B. WING _____	C 05/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY GROUP HOME	2221 FAIRWAY LANE 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) COMPLETE DATE
M 000	INITIAL COMMENTS The following deficiency was cited during the investigation of Incident # 74858-I:	M 000		
M 204	63.8(7)a Administrator 481-63.8(135C) Administrator. Each residential care facility for the intellectually disabled shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. 63.8(7) The administrator shall: a. Be responsible for the selection and direction of competent personnel to provide services for the resident care program; This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure transportation staff were sufficiently trained which directly impacted 1 of 1 residents reviewed (Resident #1). Findings include: On 5/7/18 a review of incident reports showed on 3/16/18, Staff A transported residents on an agency bus from the facility to a dayhab program. Staff A dropped the residents off at 9:07 AM and returned to the bus parking lot which was connected to the parent agency's main office, a few minutes away from the dayhab program. Staff A exited the bus and went inside the offices. At 9:15 AM, the Transportation Manager received	M 204	Plan of Correction is attached DD 6/14/18	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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M 204	Continued From page 1 a phone call from the dayhab program inquiring why Resident #1 did not get dropped off. The Transportation Manager immediately went and looked inside of the bus. When he walked through the bus he discovered Resident #1. Resident #1 could not be seen from the front of the bus because of the high seats and his/her short stature. According to weatherunderground.com, it was 30 degrees and sunny on 3/16/18 at 9:00 AM in Waterloo, Iowa. Review of Resident #1's record on 5/7/18 revealed he/she was 65 years old and had diagnoses including a profound intellectual disability and blindness. The resident was 4'9" tall and often sat hunched over on the bus. Observation of the bus on 5/7/18 revealed the front portion of the bus was reserved for wheelchairs. The back half of the bus contained several rows of passenger seats with high backs. On 5/7/18 a review of the agency's Transportation Manual revealed on page 14 in section 8 regarding "Leaving the Bus at the End of the Route," drivers were directed to "Check all seats for riders by walking through the entire length of the bus. A good practice is to check the right side while walking to the back of the bus and the other side while walking forward. Riders may be sleeping or too short for you to see." On 5/8/18 at 10:20 AM, Staff A stated he had just returned to work after being off for 60 days for medical reasons. When he returned to work, he had a different bus to drive with higher seats and different residents as passengers. Staff A stated when new residents began riding the bus or a bus driver got a new route, no information was generally given to the bus driver about the	M 204		

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M 204	Continued From page 2 residents. When asked if it was procedure to do a "walk-through" of the bus after each trip, Staff A stated "No." When asked if he had received a copy of the Transportation Manual, he stated he had never seen it prior to the incident on 3/16/18. Interview with the Associate Data Management Director on 5/21/18 at 3:00 PM revealed Staff A was initially hired by the agency in November 2015. He left in January 2018 for medical reasons, and was rehired on 3/12/18. On 5/8/18 at 11:22 AM, Staff B stated she had worked as a bus driver for the agency for almost 24 years. Staff B stated she had not seen the Transportation Manual since "the early 2000s." She added she had been told to do walk-throughs of buses, but it was a long time ago and someone newer like Staff A would not have received this directive. On 5/7/18 at 12:19 PM, the Transportation Manager confirmed his staff had not been trained regarding the Transportation Manual.	M 204		
M 508	63.23 Safety 481--63.23(135C) Safety. The licensee of a residential care facility for the intellectually disabled shall be responsible for the provision and maintenance of a safe environment for residents and personnel (III)	M 508		

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M 508	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to provide a safe environment for 1 of 1 residents reviewed (Resident #1). Findings include: On 5/7/18 a review of incident reports showed on 3/16/18, Staff A transported residents on an agency bus from the facility to a dayhab program. Staff A dropped the residents off at 9:07 AM and returned to the bus parking lot which was connected to the parent agency's main office, a few minutes away from the dayhab program. Staff A exited the bus and went inside the offices. At 9:15 AM, the Transportation Manager received a phone call from the dayhab program inquiring why Resident #1 did not get dropped off. The Transportation Manager immediately went and looked inside of the bus. When he walked through the bus he discovered Resident #1. Resident #1 could not be seen from the front of the bus because of the high seats and his/her short stature. According to weatherunderground.com, it was 30 degrees and sunny on 3/16/18 at 9:00 AM in Waterloo, Iowa. Observation of the bus on 5/7/18 revealed the front portion of the bus was reserved for wheelchairs. The back half of the bus contained several rows of passenger seats with high backs. Review of Resident #1's record on 5/7/18 revealed he/she was 65 years old and had diagnoses including a profound intellectual disability and blindness. Review of Resident #1's individual service plan dated 8/1/17 revealed	M 508		

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M 508	Continued From page 4 he/she was not to have any unsupervised time in the home or in the community. Interview with the Transportation Manager on 5/7/18 at 12:19 PM revealed Resident #1 was left unsupervised on the bus for approximately 4 minutes on 3/16/18. The resident received no injuries as a result of this incident.	M 508		