Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **6870**			**Date:** **December 13, 2018**
Facility Name: **Glenwood Resource Center**		**Survey Dates:** **November 5, 6, 7, 2018**	
Facility Address/City/State/Zip **711 S. Vine St.** **Glenwood, IA 51534**			
	LK		

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**
W189	Based on interviews and record review, the facility failed to ensure staff effectively and competently demonstrated the skills and/or awareness to implement facility policy and procedure for supervision and safety of clients. Staff failed to consistently implement facility policy and procedures related to client elopement and zoning. This affected 1 of 1 client (Client #1) identified as a result of investigation #79198-I. Finding follows:			

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	1. Record review revealed the following: a. Client #1's Incident Report, dated 9/21/18, documented by Treatment Program Manager (TPM) A, noted, "This TPM was in Building 115 retrieving a radio, as I exited the building, I could see (Client #1) walking across the parking lot. She was already to the street heading in the direction of the Corner Shop/Visitor's Center. I got in my car and drove around the side of the building adjacent to the Storeroom and (Client #1) was nowhere to be seen. At approximately 1:30 p.m., I called out to house 355 and they indicated they did not see (Client #1). RTW (Resident Treatment Worker A) joined in the search at approximately 1:40 p.m. and checked the Corner Shop. She indicated she did not see her in there. I notified (Resident Treatment Supervisor (RTS) A) at approximately 1:34 p.m., (Treatment Program Administrator (TPA) A) at 1:42 p.m., and (Interim Quality Management Director (QMD)) at 1:54 p.m." b. Summary of the Facility investigation, dated 9/28/18, documented: "RTW A checked on Client #1 between 1:15 p.m. and			

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	1:30 p.m. At approximately 1:30 p.m., TPM A observed Client #1 walking south through Building 115 parking lot towards the east side of the storeroom. TPM A did not communicate with Client #1 or attempt to follow her. TPM A got into his car, drove around the west side of the storeroom, and could not locate Client #1. According to TPM A's phone log, at 1:31 p.m. he called House 355 to see if they knew where Client #1 was. At 1:34 p.m., TPM A notified RTS A of Client #1's elopement. At 1:42 p.m., TPM A notified TPA A of Client #1's elopement. At 1:51 p.m., TPM A called the QMD's office and no answer. At 1:54 p.m., TPM A notified Psychology Assistant A of Client #1's elopement. Psychology Assistant A handed her phone to the QMD and TPM A notified her of Client #1's elopement. Between 1:54 p.m. and 2:30 p.m., the facility formed a search team and began searching for Client #1. RTS B sat in her office on the second floor of the Visitor's Center and heard a noise in the conference room. RTS B walked into the conference room and observed someone walking out of the southeast door. RTS B asked what they were doing, and a female voice responded "nothing." Approximately five minutes later, members of the search			

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	team walked up to the second floor of the Visitor's Center and RTS B reported what she observed. Between 2:30 p.m. and 2:45 p.m., RTS B heard the stairwell door and found Client #1. The summary also indicated, "Evidence supports (Client #1) left House 355 sometime between 1:15 p.m. and 1:30 p.m. (Client #1) then took the sidewalk north of the baseball/soccer fields and headed west. Once to the Meyer (building) (Client #1) turned and went south towards the (building) 115 parking lot and storeroom. This is when (TPM A) observes (Client #1). (Client #1) crossed the road and entered the Visitor's Center without being seen by (TPM A). (Client #1) reported she was in the basement, but evidence supports she spent time on all three levels of the building prior to being found by (RTS B) on the second floor." Further record review revealed the following: a. The diagnosis of Client #1, age 30 at the time of the incident, included: mild intellectual disability and bipolar disorder. b. Client #1's Behavior Support Plan (BSP) dated 6/29/18 included elopement as a targeted behavior. The plan defined			

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	elopement as, "Location is unknown by staff who are assigned responsibility for oversight, she does not arrive/return when expected, or she leaves without permission and is no longer in continuous staff oversight." The plan indicated when Client #1 eloped to follow the facility policy for elopement. The plan also indicated Client #1's supervision level was 10-minute checks. c. Facility Incident Management Policy dated 6/2/17, indicated, "When a staff determines that an individual's location on campus is unknown; notify a supervisor and initiate search immediately. If the individual is not found within 15 minutes the designated supervisor shall immediately notify the administrative officer of the day, and Superintendent/Superintendent's designee. The Superintendent or designee shall: Implement an organized, extended search; Determine when to end the extended search; Contact law enforcement for assistance per established agreements, when the individual presents a danger to self or others or has not been located within 15 minutes of the initiation of the extended search. According to Google Maps, Client #1 traveled			

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	a distance of approximately .39 miles. According to wunderground.com, on 9/21/18 at 1:11 p.m. the temperature was 63 degrees Fahrenheit (F). When interviewed on 11/6/18 at 9:05 a.m. RTW A reported on 9/21/18 she arrived to work early to help cover because of a homecoming parade. RTW A worked with Client #1 for approximately four years. They had just moved to House 355 from House 470. House 355 had a different floor plan than House 470. According to RTW A, if they did not have proper staff numbers, it was difficult to supervise everyone. She stated staff numbers did not play a role in Client #1's elopement on 9/21/18. RTW A stated Client #1 was on restriction and could not attend the parade. She was unsure why Client #1 was on restriction. RTW A stated Client #1 did not display any precursor behaviors. She checked on Client #1 at 1:30 p.m. and she was in the kitchen putting dishes away. Everyone else in the house was relaxing. RTW B had accountability of the client with one-to-one supervision and RTW C had accountability on the other side of the house. RTW A told RTW B she was going outside to			

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	smoke, but she should have told RTW C to watch her zone. RTW A was unsure if RTW C should have signed the zone papers. RTW A stated Client #1's supervision level was 15-minute checks. She was unsure how the zone sheets played the 15-minute checks. RTW A confirmed the facility trained her on the zone sheets, but the facility completed formal training when she was out of the house. TPM A called the house at 1:34 p.m. and stated Client #1 was across campus. RTW A called for a bus to help look for Client #1, but nobody answered. She drove her car around the campus looking for Client #1 until approximately 2:00 p.m. At 2:00 p.m., she went back to the house while others continued the search. According to RTW A, Client #1 eloped all the time. She stated a lot of the time Client #1 eloped to the Corner Shop, especially if she had money. Client #1 only carried $3.00 at a time, per a restriction. She was obsessed with food. The Corner Shop had candy and soda. RTW A believed this incident was the first time Client #1 eloped without a staff in site. RTW A stated Client #1 had a hard time dealing with her mom's recent health issues and that could be contributing to some of her issues. RTW A denied seeing Client #1 walk out of the			

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	house. She stated Client #1 had long sleeves and pants on and was dressed appropriate for the weather. When interviewed on 11/5/18 at 1:30 p.m. RTW B reported on 9/21/18 she was accountable for a one-to-one client. Client #1 was on restriction and could not attend the parade. She stated RTW A informed her she was going outside to smoke. RTW B walked around with her client and witnessed RTW A check on Client #1 before going outside. Approximately five to seven minutes after she walked outside, TPM A called the house and asked if they knew where Client #1 was. RTW B was shocked Client #1 eloped. RTW B left work before they found Client #1. According to RTW B, they just moved to House 355 and the House had more doors than the old House. She stated the floor plan made it difficult to supervise clients if they ran short staffed. RTW B stated they had enough staff on 9/21/18. They moved to House 355 to separate the behaviors in the house. RTW B explained Client #1 had not had a good year. RTW B used to have a good relationship with Client #1, but does not have that relationship now. She stated Client #1 was upset because of her mom's health			

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	and she obsessed over food. RTW B was nervous Client #1 would try to go to the parade because of the kids that attended. RTW B explained how Client #1 had issues with kids and they try to keep her away from them. Client #1 did not attend counseling anymore because it was not productive. RTW B stated Client #1's supervision level was 10-minute checks. Client #1 used to go on one-minute accountability but now they had Zoning. She stated they still have to do the checks on the clients according to their behavior support plans. When interviewed on 11/5/18 at 2:15 p.m. RTW C reported on 9/21/18 she worked in House 355. She stated House 355 was two sided. RTW C was accountable for two clients on side A and was the medication passer. Client #1 resided on side B. RTW C stated House 355 had exit doors on each side of the house, one in the back of the house and one in the front. RTW C could not remember if the clients attended work earlier in the day, but they did not have work that afternoon because of the homecoming parade. Client #1 was on restriction, possibly due to aggressions. RTW C stated Client #1 was up and down in her behaviors.			

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	According to RTW C, Client #1 was not in a good place. Client #1 worried about who was working, looked for something, liked to argue with her peers, and had some family issues going on that are affecting her. RTW C stated Client #1 was an opportunist and would dart out the door when staff looked away. She liked to try certain staff. RTW C stated Client #1's supervision level included 10-minute checks and to know her whereabouts at all times. RTW C explained when Client #1 is on restriction; staff should be mindful of where she is and check on her often. RTW C did not trust Client #1. When RTW C is accountable for Client #1, she gives Client #1 clear expectations of the day. RTW C denied knowledge of RTW A leaving the house to smoke. RTW C stated she would have asked Client #1 to come over to side A while RTW A went outside. According to RTW C, TPM A called at 1:30 p.m. and asked if they knew where Client #1 was. TPM A informed them Client #1 was in Building 115 parking lot and headed towards the Corner Shop. RTW C told RTW A to go try to find her. RTW C left her shift at 2:30 p.m. and Client #1 had not returned. When interviewed on 11/5/18 at 4:20 p.m.			

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	TPM A reported on 9/21/18 he worked the evening shift. TPM A walked out of Building 115 and looked across the parking lot where he observed a client walking south. According to TPM A, the quickest way to get to Client #1 was to get into his car and try to meet her on the other side of the building. When TPM A drove around the building, the client was gone. TPM A called House 355 and asked if they knew where Client #1 was. TPM A stated he did not get a good visual on the client, although thought it was Client #1. TPM A talked to RTW C. She told him she was not on Client #1's side of the house. RTW C saw RTW A outside and they looked for Client #1. TPM A drove around the building three or four times and could not locate Client #1. RTS A assisted in the search. TPM A tried to call the QMD in her office, no answer. He notified a staff at the parade; the staff stood next to the QMD. Staff handed the QMD the phone and TPM A reported the incident. The QMD returned to the campus and TPM A notified TPA A. TPA A informed TPM A to formulate a search group. They started a search group and broke off into pairs. TPM A drove into town to search for Client #1. TPM A stated Client #1 was located in the Visitor's Center. He			

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	drove back onto campus and drove Client #1 and RTS A back to House 355. TPM A explained Client #1 could not attend the parade because she was on a restriction. According to TPM A, the elopement was the first elopement Client #1 had "in years." He stated she had a couple elopements, according to policy, but staff had eyes on her within seconds. Following Client #1's elopement in June, they added elopement to Client #1's BSP and suspended her campus mobility. After 9/21/18, they added Client #1 her own staff. TPM A stated Client #1 was not considered one-to-one supervision, they just add an extra staff to the house. TPM A also stated Zoning is technically continuous supervision. The facility also took out campus mobility from her BSP and reduced the response cost. TPM A confirmed RTW A should have communicated to RTW C she took a break. When interviewed on 11/5/18 at 2:30 p.m. RTS B reported on 9/21/18 she sat in her office. Her office is located above the Corner Shop on second floor with the Visitor's Center. She was making her phone calls for the beginning of the shift. Nobody else was in the building. RTS B heard someone come			

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	up and thought she heard a candy wrapper sound. She could not see out of her office door from where her desk is located. She walked out of her office and observed the back door ajar. She said, "Hello, do you need something?" The person said, "No" and left. Approximately five to 10 minutes later part of the search team showed up and asked if she saw Client #1. RTS B reported what she witnessed and wondered if it was Client #1. RTS B stated they made an overhead announcement, but she does not have an overhead intercom in her office and she would not know what Client #1 looked like. She walked to the stairwell and saw a candy wrapper. She worked her way to the basement and went back upstairs. Approximately another 10 minutes went by and she heard someone come back upstairs. RTS B walked out of her office and Client #1 stood there. RTS B blocked her from leaving and talked her into sitting in her office. Client #1 used the bathroom and sat down for candy. RTS B notified the search team and they came to get her at approximately 2:40 p.m. Client #1 told RTS B she was upset because someone at the house was one-to-one. Client #1 stated she hid in the basement. RTS B noticed Client #1 had dirty			

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	shoes and pants. She stated she wore sweat pants and a jacket. Client #1 was dressed appropriately for the weather. When interviewed on 11/6/18 at 12:30 p.m. the QMD confirmed the facility failed to follow the Incident Management Policy related to Elopement. She stated they organized the search team and the notified local law enforcement after the 15-minute timeframe. 2. Record review revealed the following: a. Client #1's Incident Report dated 9/21/18 documented by TPM A, indicated, "This TPM was in Building 115 retrieving a radio, as I exited the building, I could see (Client #1) walking across the parking lot. She was already to the street heading in the direction of the Corner Shop/Visitor's Center. I got in my car and drove around the side of the building adjacent to the Storeroom and (Client #1) was nowhere to be seen. At approximately 1:30 p.m., I called out to house 355 and they indicated they did not see (Client #1). (RTW A) joined in the search at approximately 1:40 p.m. and checked the Corner Shop. She indicated she did not see her in there. I notified (RTS A) at			

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	approximately 1:34 p.m., (TPA A) at 1:42 p.m., and (QMD) at 1:54 p.m." b. Client #1's BSP indicated Client #1's supervision level was 10 minute checks. c. zone B indicated RTW A took over accountability of Client #1 at 1:00 p.m., no other staff documented as accountable for Client #1. Further record review revealed Facility Zoning Policy dated 8/26/18, indicated, "The whereabouts of individuals supported at GRC shall be known by the staff responsible for their care. Staff must ensure the whereabouts of all individuals throughout the day, night, and during the cross-over time between staff. Staff leaving duty must assure that oncoming staff taking over responsibility of individuals is aware of the location of each person residing in the home." The policy also indicated, "Staff responsible for individual(s) must have ongoing knowledge of individuals' whereabouts. The staff responsible must maintain knowledge of individuals' whereabouts by maintaining a Zoning Sheet. Individuals with varying levels of supervision outlined in Behavior Support Plan (BSP) will			

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	be accounted for as specified in BSP." When interviewed on 11/6/18 at 11:30 a.m. TPM A confirmed the facility failed to follow the Zoning policy, as staff did not know Client #1's whereabouts. When interviewed on 11/6/18 at 12:30 p.m. the QMD confirmed the facility failed to follow the Zoning policy. **FACILITY RESPONSE:**			

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