STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G051	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILLAR OF CEDAR VALLEY	1410 WEST DUNKERTON ROAD WATERLOO, IA 50703

(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 At the time of investigation #84864-I, a deficiency was cited at W191.	W 000	This plan of correction constitutes Pillar of Cedar Valley credible allegation of compliance. This allegation does not constitute an admission of guilt, but rather stipulates that Pillar of Cedar Valley continues to meet the applicable provision of the state and federal regulations.	
W 191	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to provide adequate supervision for a client with a known history of elopement. This affected 1 of 1 client identified during the investigation of #84864-I (Client #1). Finding follows: Review of facility investigation on 8/14/19 revealed Client #1 eloped from the facility on the morning of 7/20/19. The client had a known history of elopement and had been in her bedroom with her roommate, with a door alarm turned on. The roommate (Client #2) opened the door and turned off the alarm, in order to use the bathroom. A staff person saw the two clients and told them to return to their room. The staff person went to get assistance and the clients left their room. Client #1 exited the building out of the patio exit door, which was supposed to be alarmed, but apparently malfunctioned. Client #1 left the building at 9:13 a.m. and went into a nearby cornfield. Staff and the sheriff's department searched for Client #1. She exited the cornfield at 11:07 a.m. according to the facility investigation. Client #1 reportedly had multiple superficial cuts, but the facility was unable to locate the nursing assessment at the time of the DIA investigation.	W 191	POC 10/18/19 **W191** Pillar of Cedar Valley will continue to ensure employees who work with clients are trained with a focus on skills and competencies directed toward clients' behavioral needs. The Program Manager will develop a policy for client supervision and will train all staff on policy by 10/18/2019. After the initial investigation of this incident on 7/31/19, staff on Aspen were provided further education on general client supervision of all Aspen clients and staff break times. The Program Manager, Support Service Specialist and Program Supervisors will complete random observation or audits to ensure staff are taking meal breaks at their scheduled time. Observation or audits of the client turn over process will also be conducted when the primary staff leave the area to ensure responsibility of the client has been communicated. For individuals who are out of the programming areas, the staff will continue to use client tracking boards in each area that states whether they are in/out of program area and when the next check will occur.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelia Sisler	Administrator	9/6/19

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 191	Continued From page 1 According to the website Weather Underground the high temperature in Waterloo on 7/20/19 was 89 degrees Fahrenheit with 91% humidity. Record review on 8/14/19 revealed Client #1 was 27 years old with a diagnosis including mild intellectual disability, depression, borderline personality disorder, bipolar I disorder and impulse control disorder. Client #1 was admitted to the facility on 12/17/18 and had a history of elopements and elopement attempts at the facility. Client #1 had a behavior support program (BSP) in place to address multiple maladaptive behaviors including elopement, self-harm, aggression, non-compliance, seeking to go to the hospital, lying/making untruthful statements and inappropriate use of the phone (including making 911 calls). Restrictive measures in Client #1's BSP included an alarm on her bedroom door when she was in her room and the use of 4-point restraint for aggression and self-injurious behavior. Client #1 also had a level systems in which she earned privileges based on her behavior. Client #1's BSP noted she should be monitored at all times during transitions and might require closer supervision when having increase behavioral issues. Client #1 had an Environmental Strategies Consent for one hour room checks when she was in her room. According to the Psychiatric Progress Notes dated 7/22/19, Client #1 told her psychiatric nurse practitioner that she found a piece of glass in the cornfield on 7/20/19 and used it to cut herself. The nurse practitioner noticed that some of the cuts on Client #1 didn't appear to be consistent with brushing against corn stalks. Client #1 told the nurse practitioner that she also banged her	W 191		

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W 191	Continued From page 2 head a few times while in the cornfield. Observation on 8/14/19 revealed the IC/ID facility is on a first floor wing of a large 3 story building. Staff refer to the ICF/ID unit as the Aspen unit. The building is located in the countryside and surrounded by cornfields on the west, north and east. A two lane county road is on the south side of the building. The Aspen unit has a long hallway, with client bedrooms, day rooms and staff offices off of the hallway. The hallway curves to toward the east about midway, creating a front hallway and a back hallway. The middle/central area contains the enclosed nurses' office/station, a day room called the patio room and a day room called the PT room. Client #1's bedroom is about halfway down the front hallway, between the double doors leading to the unit and the middle/central area. An alarm box with numbers is located outside of her bedroom door. When interviewed on 8/15/19 at 10:00 a.m. Client #2 said she and Client #1 were in their bedroom on the morning of 7/20/19. The bedroom door alarm was turned on. Client #2 said she needed to use the bathroom, so she turned on her call light, but no one came to turn off the alarm so they could leave the room. Client #2 said she really needed to use the restroom and Client #1 wanted to talk to the nurse. Client #2 opened the door and turned off the alarm, using the code. She said knew the code because she overheard staff. After she opened the door and turned off the code, Developmental Aide (DA) D came and told Client #1 and Client #2 to go back to their rooms and then she left the unit. Client #2 went to the bathroom and she saw Client #1 head to the nurses' office. Client #2 did not know that Client #1 was going to leave the building.	W 191		

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W 191	Continued From page 3 When interviewed on 8/15/19 at 10:15 a.m. Client #1 stated she and Client #2 were in their bedroom on the morning of 7/20/19 with the door alarm turned on. Client #2 needed to use the bathroom and turned on the call light, so staff would come and let them out of the room, but no one came. Client #2 opened the bedroom door, turned off the alarm and went to the bathroom. Client #1 went out the patio exit door and went to the cornfield. She said she was mad at the time. She didn't recall if the patio door alarm sounded. Client #1 said it was very hot in the cornfield. She found a piece of glass and cut herself with it. She knew people were looking for her and she finally came out of the cornfield. When interviewed on 8/14/19 at 3:00 p.m. DA A stated she was assigned to Client #1 and three or four other clients on the morning of 7/20/19. There was a movie in the community room as the morning activity. (The community room is off of the Aspen unit, but nearby on the first floor.) Client #1 and Client #2 didn't want to go to the movie. Client #1 said her knee hurt and she wanted to rest in her room. It was not unusual for Client #1 to complain of aches and pains. Client #1 did not appear to be agitated or upset. DA A made sure Client #1 was in her bedroom and then shut the door and turned on the door alarm. She said she reminded the two clients to use the call light if they needed anything. DA A said she thought she told DA B in passing that Client #1 was in her room, but said he might not have heard her. DA A estimated she went to the movie in the community room with her other clients around 8:30 a.m. At some point DA D said she was going on break and left the community room, but she returned and told DA A that Client #1 was	W 191		

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W 191	Continued From page 4 out of her bedroom and Client #2 entered the alarm code. DA A and DA D quickly went to the Aspen unit. DA A said the bedroom door was open and there was no sign of Client #1. Client #2 was in the bathroom. There were no alarms sounding. Staff searched the unit and then called the on-call supervisor. A Code White was announced (missing client) and staff called 911. Sheriff deputies arrived to help with the search. Various staff positioned themselves around the cornfield, but had not gone in the cornfield to search because it was private property and the sheriff's office has told staff not to go into the cornfield. Client #1 later walked out of the cornfield on her own. She was bleeding from cuts, which appeared to be minor. DA A said Client #1 had history of elopement and had gone into the cornfield before. Client #1 must have exited through the patio door, which should have alarmed, but the staff later discovered the alarm wasn't working. When interviewed on 8/14/19 at 3:20 p.m. DA B said he was working on the Aspen unit on the morning of 7/20/19. Most of the clients and staff had gone to the community room to watch a movie. DA B said he and DA C were the only two staff on the Aspen unit with 4-5 clients that he knew of. DA B said he had no idea that Client #1 and Client #2 were in their shared bedroom. He said he sat in the middle area of the hallway, near the nurses' office, for a while so he could monitor both hallways. A client came out of his room in the back hallway and needed assistance due to a toileting accident. DA B went back to assist the client. Shortly before that, DA C had gone on break, leaving DA B as the only staff person on the Aspen unit. DA B said he he would not have left the front hallway unsupervised if he had	W 191		

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W 191	Continued From page 5 known that Client #1 was in her room. He said he didn't hear an alarm when he was in another client's bedroom in the back hallway. When interviewed on 8/15/19 at 9:00 a.m. DA C stated she was working in the Aspen unit with her assigned clients on the morning of 7/20/19. She was with her clients in a day room area (Room 110) in the back hallway. DA C said she didn't know of the movie activity and initially didn't realize most of the other clients and staff left the unit. DA C and DA B were on the Aspen unit with around seven clients after the others left. DA C said DA A did not tell her that Client #1 was in her room. DA C said staff were supposed to "report off" and transfer client responsibility as needed, but DA A had not done that. DA C said she took a break from approximately 8:40 a.m. to 8:55 a.m. Around 9:10 a.m. DA C got a phone call about a sick family member. She took another break and told DA B. DA C estimated she left the Aspen unit around 9:10 a.m. While she was on break, another staff came and told her that Client #1 was missing. DA C said had she known Client #1 was in her room, she would made sure a staff person was monitoring Client #1's door or hallway. When interviewed on 8/15/19 at 9:25 a.m. DA D stated on the morning of 7/20/19 she had been in the community room, at the movie activity. She left to take a break around 9:10 a.m. She was heading toward the front doors of the building when she heard the alarm on the Aspen unit. DA D went through the double doors of the unit and saw Client #2 with her hand over the alarm trying to muffle the sound and entering the code to turn off the alarm. Client #1 was near Client #2, in the doorway area. Client #2 told DA D that she needed to go to the bathroom. DA D told the two	W 191		

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W 191	Continued From page 6 clients to go back into their room and she left the Aspen unit to get staff assistance from the community room. She got DA A and they returned to the Aspen unit in a minute or less, but when they returned, the Client #1 was not in sight. There were no alarms sounding. The patio exit door alarm should have been sounding if Client #1 went out that door, but they later discovered the exit door alarm hadn't worked. When interviewed on 8/15/19 at 10:30 a.m. the Qualified Intellectual Disability Professional (QIDP) stated she spent hours looking at the multiple camera videos at the time of the incident and had a timeline of the events. The video from 7/20/19 was not available when the surveyor asked about it on 8/13/19. The QIDP said she had not noted the time when DA A turned on Client #1's bedroom door alarm. The QIDP reviewed her notes regarding the timeline of events on the morning of 7/20/19: 8:46 a.m.: DA B was sitting in the middle hallway area, near the nurses' office, monitoring the two hallways. 8:57 a.m.: DA B was still sitting in the middle hallway, monitoring both hallways. (The QIDP explained there were clients in their rooms on both hallways who stayed back from the movie.) 9:06 a.m. DA B went down the back hallway. DA C and a nurse were in the same back hallway, at a client's bedroom. 9:06 a.m. DA B was at the nurses' office, getting soap. He and DA C passed each other as he went back down the back hallway and she was coming toward the patio day room. DA C exited the unit through the patio exit door. 9:07 a.m.: DA B was in the back hallway, attending to a client. The call light went on above Client #1 and Client #2's bedroom door.	W 191		

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W 191	Continued From page 7 9:12:22 a.m.: Client #2 opened the bedroom door and reached her hand up to muffle the alarm and enter the code to turn off the alarm. Around this same time, DA D came into the Aspen unit through the double doors and spoke with Client #1 and Client #2, who were standing near their bedroom doorway. DA D then ran off the unit, through the double doors. 9:13:22: Client #1 was out of her bedroom, in the central area, looking in to the nurses' office and around the patio room area. 9:13:35: Client #1 went out the patio exit door. She was out of camera range by 9:13:44. 9:13:43: DA A and DA D entered the Aspen unit through the double doors. The QIDP stated the staff person assigned to Client #1 (DA A) should have told DA B and DA C that Client #1 was in her room and DA A was passing responsibility to the other staff. The QIDP said DA A admitted she had not "reported off" to DA B or DA C like she should have. The QIDP said staff were supposed to follow scheduled break times. DA C had 15-minute scheduled breaks at 8:15 a.m. and 9:30 a.m. on 7/20/19. When interviewed on 8/14/19 at 2:30 p.m. the Program Manager (PM) confirmed DA A was the staff person assigned to Client #1 at the time of the incident. DA A went to the community room for a movie activity. DA A should have notified other staff that she was leaving the unit and Client #1 was in her bedroom. DA A said she told DA B that Client #1 was in her bedroom. DA B and DA C were the only two staff on the Aspen unit during the activity in the community room, other than staff who might have been coming and going to assist clients to the restroom. The PM estimated	W 191		

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W 191	Continued From page 8 DA B and DA C were responsible for four to six clients on the Aspen unit, who had not gone to the movie. DA B monitored both hallways, but he then needed to assist a client in the back hallway. DSA C left the unit, to take her break earlier than scheduled, leaving DA B the only staff person supervising the Aspen unit. A nurse was present in the medication/nurses' office, but she was passing medication and was not responsible for directly supervising clients. DA D heard the bedroom door alarm sounding when she passed by the Aspen unit while going on break. She saw Client #1 and Client #2 out of their room and near the bedroom doorway. DA D told the two clients to go back to their room and she want to get additional staff assistance. The PM said it could be difficult for one staff person to manage Client #1 if she became behavioral. Client #1 left the bedroom and eloped out of the patio door. The alarm on the patio door should have sounded, but it malfunctioned. During a follow-up interview on 8/15/19 at 1:45 p.m. the PM confirmed DA A should have clearly transferred the responsibility of Client #1 to another staff person when DA A left the Aspen unit on the morning of 7/20/19. Since the incident, the facility had a staff meeting on 7/31/19 and reviewed the importance of transferring client supervision to other staff when needed. They also reviewed the elopement incident, general client supervision and staff break times. The patio door alarm was fixed on 7/20/19 and a second back up alarm was installed on the door. The PM was unable to locate an agency policy specific to client supervision, but did provide a staff training sheet for new staff that included the following: "Explain the importance of turning over clients to another	W 191		

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W 191	Continued From page 9 staff when leaving the area."	W 191		