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 11/21/2019

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 Deficiencies were cited at W153 and W289 as the result of the investigation of #87185-M	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff immediately reported allegations of suspected abuse. This affected 1 of 1 client identified in the investigation of #87185-M (Client #1). Finding follows: Review of a facility investigation regarding allegations of dependent adult abuse revealed the facility conducted an investigation regarding an allegation made on 10/13/19 a staff person hit Client #1 during an altercation between the client and multiple staff. During the course of the facility investigation, several staff people were interviewed. The facility interviewed Developmental Aide (DA) B on 10/16/19, three days after the incident. DA B had witnessed the altercation. He stated he had not seen the accused staff person hit Client #1, but he said he saw DA A put her arm around Client #1's neck while trying to restrain her, in what appeared to be a choke hold. When interviewed on 11/18/19 at 1:20 p.m. DA B	W 153		

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

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W 153	Continued From page 1 stated he saw DA A get behind Client #1 as the client was being aggressive toward staff on the afternoon of 10/13/19 and DA A put her arm around Client #1's neck, like a choke hold. DA B estimated DA A had her arm around Client #1's neck for a few seconds, before the client bit DA A and staff person then released her hold. When asked why he didn't report this until three days after the incident, DA B said it all happened very quickly and he thought about it more when he was questioned about the incident on 10/16/19. DA B also stated that he assumed the management staff would watch the video of the incident and see for themselves what occurred. (The altercation occurred in a hallway that typically was monitored by a video camera, but the camera was not working at the time of the incident.) According to the facility Abuse Reporting policy dated 1/25/18, "All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative." When interviewed on 11/20/19 at 10:30 a.m. the ICF/ID Program Manager confirmed DA B should have immediately reported the allegation of DA A putting her arm around Client #1's neck to restrain her, if DA B believed the action was purposeful and not a brief accidental slip during the struggle.	W 153		
W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4)	W 289		

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W 289	Continued From page 2 The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to develop and implement a behavior support program (BSP) in conjunction with the use of restrictive measures for a client with behavioral issues. This affected 1 of 1 client identified during the investigation of #87185-M (Client #1). Findings follow: Record review on 11/18/19 and 11/19/19 revealed Client #1 admitted to the facility on 8/28/19. Client #1 had been discharged from a prior ICF/ID facility due to behavioral challenges. Client #1 was 19 years old with a diagnosis including Mild Intellectual Disability, Schizoaffective Disorder, Post Traumatic Stress Disorder, Adjustment Disorder and Morbid Obesity. Client #1 was admitted to the facility on three psychotropic/behavior modifying medications. Her 30 day staff meeting was held on 9/25/19. The behavior report written by the Behavior Specialist noted Client #1 took prescribed psychotropic medications, had an alarm on her bedroom door and had a locked, Plexiglas bedroom window. Since her admission, Client #1 displayed maladaptive behaviors that had been of low to moderate intensity. The behaviors included aggression toward others, verbally inappropriate behavior, self-harm or threats of self-harm/elopement, and property destruction.	W 289		

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W 289	Continued From page 3	W 289		

The behavior report noted staff attempted to place Client #1 in an emergency 4-point restraint bed on 9/10/19, but the restraints did not fit around her wrists and ankles. The behavior report indicated a behavior program would be developed to address verbal interactions, aggression, property destruction, self-harm and elopement and would be implemented in conjunction with the psychotropic medication regime. Additional restrictive measures would include removal of personal items as needed for attempts to aggress or self-harm, locked/frosted window, earned use of Aspen (living unit) electronics and privileges. As of 11/19/19, no behavior program had been developed for Client #1.

Additional record review revealed Client #1 had a significant behavioral episode on the afternoon of 10/13/19, involving multiple staff. Client #1 became agitated and aggressive toward staff when a staff person told her she needed to clean her room and take a shower before using the facility phone. Several staff became involved as they tried to restrain Client #1 from injuring staff. During the altercation, two staff were accused of dependent adult abuse toward Client #1. Review of Client #1's programs revealed no information indicating her phone privileges were conditional on completing chores or hygiene tasks.

When interviewed on 11/18/19 at 4:45 p.m. the Behavior Specialist confirmed no BSP had been developed for Client #1 since her admission. She said she was still getting baseline information on Client #1's behaviors. The Behavior Specialist said when Client #1 had a behavioral upset it was usually regarding phone use and not wanting to comply with hygiene expectations, such as showering. According to the Behavioral

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W 289	Continued From page 4 Specialist, Client #1's overall behaviors had not been very frequent or severe. She said the incident on 10/13/19 had been the most severe behavioral episode Client #1 had at the facility. The Behavior Specialist acknowledged that a BSP should have been developed and implemented by now, especially considering the restrictive measures in place. When interviewed on 11/19/19 at 4:15 p.m. the ICF/ID Program Manager confirmed staff should not have told Client #1 that she needed to clean her room and take a shower before she could use the phone on 10/13/19. There were no programs or restrictions in place regarding phone use. The Program Manager acknowledged the facility should have developed a BSP by this time to address Client #1's maladaptive behaviors.	W 289		