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 08/06/2020

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 The investigation of #88494-I was conducted 7/23/2020 - 8/6/2020. As a result of the investigation, deficiencies were cited at W125, W153, and W154. In addition the the investigation, the onsite Infection Control Survey was conducted. No deficiencies were cited from the onsite Infection Control Survey.	W 000	See attached POC 10/16/20	
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure guardian written informed consent was obtained for all restrictive measures utilized. This affected 1 of 1 client (Client #1) involved in the investigation of incident #88494-I. Finding follows: Record review on 7/23/2020 revealed a facility internal investigation, initiated 12/9/2019. According to the investigation, on 12/8/2019 Client #1 exhibited maladaptive behaviors and staff assisted him to his bedroom to calm down. While in his bedroom, Client #1 grabbed Team Lead (TL) A's shirt and began hitting, kicking, and scratching. TL A put his arm up to block Client #1 from head butting him. The behavior continued and both Client #1 and TL A fell to the ground; Client #1 began grabbing Team Lead A's pants	W 125		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9-18-20

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 125	Continued From page 1 and attempted to bite his ankles. It was reported TLA might have stepped on Client #1's hand. Continued record review revealed Client #1 had a Behavior Intervention Plan (BIP) in place to learn to communicate his wants and needs without engaging in maladaptive behaviors. The plan addressed target behaviors including aggression towards property (throwing items, breaking items), aggression towards others (hitting, pushing, throwing items at an individual, pinching, biting, kicking, hair pulling), self-injurious behaviors (hitting his head with his hands, hitting his head on objects, biting himself, kicking objects). The BIP instructed when Client #1 began engaging in precursor behaviors, staff were to offer a change of activity, time alone in his bedroom, or offer his coloring supplies. If Client #1 began to engage in target behaviors, the BIP instructed staff to move other clients from the immediate area and offer Client #1 a break in his bedroom. If Client #1 refused to take a break, staff were to use blocking mats to minimize attention, wait three minutes and prompt Client #1 again. Staff were to continue this process until Client #1 agreed to take a break in his bedroom. If Client #1 engaged in hitting his head, staff were to place a towel or sheet under his head to protect him and prompt him to stop. When Client #1 engaged in aggression towards others, a Mandt restraint (the behavior management system utilized by the facility) was to be implemented by a Mandt certified staff. Staff were to assist Client #1 into his wheelchair and take him to his bedroom. Once in his bedroom, staff were to stay close to continue to monitor Client #1 and intervene, if necessary, to ensure safety. The BIP included Client #1 had a schedule to assist to keep track of his day, staff were to assist him to	W 125		

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W 125	Continued From page 2 read it and remind him of things he had completed. The BIP included Client #1 would earn a sticker for no incidents of target behaviors each day. After Client #1 earned three consecutive stickers, he would be able to earn a shopping trip or could pick a reinforcer from a container with various items. The BIP noted restrictive measures used included the use of behavior modifying medications (fluoxetine, buspirone, olanzapine, and clonazepam), a Mandt Restraint hold, and the use of blocking mats but failed to include the use of the wheelchair to take Client #1 to his bedroom. The record lacked a written informed consent signed by Client #1's guardian for all restrictions utilized in the BIP including the use of behavior modifying medications, a Mandt restraint hold, the use of blocking mats, or the use of the wheelchair to take Client #1 to his bedroom. When interviewed on 7/27/2020 at 11:15 a.m., the Program Coordinator (PC) provided a blank copy of Client #1's Informed Consent and provided notes to show verbal consent was obtained. The PC explained they facility had obtained guardian written informed consent, per the Consents Tracking spreadsheet, but she was not aware where the document was. She said she would try to locate the guardian signed written informed consent. Additional record review revealed Client #1's Interdisciplinary Progress Notes. According to the notes, on 3/29/2019 the facility obtained verbal consent from Client #1's guardian for the restrictions in the BIP. Review of the Consents Tracking spreadsheet	W 125		

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W 125	Continued From page 3 revealed on 2/15/2019 and 3/26/2019 verbal consent was obtained from Client #1's guardian. The spreadsheet noted the informed consent was sent to the guardian on 3/7/2019 and 3/27/2019 to be signed. The tracking spreadsheet noted the informed consent was signed on 4/2/2019. Additional record review revealed the "ICF/ID Behavior Stategist REsponsibilities", undated. The document included "Verbal and written consent must be obtained yearly for any program containing a restrictive measure..." The document continued to instruct, "Written consent must be obtained within 30 days of the verbal consent, or verbal consent must be given again". During a follow-up interview on 8/3/2020 at 9:10 a.m., the PC stated she was still looking for Client #1's signed written guardian informed consent. At the time of the exit, the facility was unable to provide Client #1's written informed consent signed by his guardian.	W 125		
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 interview and record review, facility staff failed to immediately report allegations of client mistreatment and/or abuse to the	W 153		

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W 153	Continued From page 4 supervisor, or the Administrator within one hour, per facility policy. This affected 1 of 1 client (Client #1) involved in the investigation of #88494-I. Finding follows: Record review on 7/23/2020 revealed the facility self-reported an allegation of abuse to the Iowa Department of Inspections and Appeals (DIA). The facility reported on 12/8/2019 Client #1 was exhibiting maladaptive behaviors and staff assisted him to his bedroom to calm down. While in his bedroom, Client #1 grabbed Team Lead (TL) A's shirt and began hitting, kicking, and scratching. TL A put his arm up to block Client #1 from head butting him. The behavior continued and both Client #1 and TL A fell to the ground; Client #1 began grabbing TL A's pants and attempted to bite his ankles. It was reported TL A might have stepped on Client #1's hand. Record review on 7/23/2020 revealed the facility internal investigation, initiated 12/9/2019. The facility summary of the incident noted the conclusion of the investigation was unknown based on both parties and varied witness statements. The document included the incident was reported to the DIA due to the allegation Client #1's hand was stepped on intentionally. Record review on 7/27/2020 revealed written staff statements including a statement completed by Developmental Aide (DA) A. According to DA A's statement, on 12/8/2019 Client #1 had been in several behaviors when he came from his bedroom and was attempting to hit her in the hallway. She called for help and TL A came from his office to assist. DA A documented TL A walked up, grabbed Client #1 by one arm and the back of Client #1's neck, and pushed Client #1 inside his	W 153		

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W 153	Continued From page 5	W 153		

bedroom. DAA continued to note Client #1 reached out, grabbed TLA's shirt, and both TLA and Client #1 fell to the ground. TLA again grabbed the back of Client #1's neck while yelling at Client #1 to release his shirt. DAA reported she and DA B attempted to get Client #1 to de-escalate and to release TLA's shirt. DAA documented after TLA was able to get up off the floor, he walked by Client #1 and kicked him on the back, leaving Client #1 on the floor as TLA exited the bedroom. DAA documented TLA stated he "had it" and to "just leave Client #1", Client #1 reached over, grabbed TLA's pants, and attempted to bite his ankle. DAA noted TLA stepped on Client #1's hand and Client #1 released TLA.

Continued review of the written staff statements revealed a statement completed by DA B. DA B noted on 12/8/2019 Client #1 was having a behavior outside of his bedroom and mats were used to keep Client #1 inside the room. DA B documented Client #1 had raised his fist toward TLA and she attempted to intervene. DA B continued to note, before she could get around the mats, Client #1 fell to the ground, below TLA, and attempted to bite TLA's ankle. DA B documented TLA kicked Client #1's head away. DA B noted she got in front of Client #1, Client #1 threw his shoe at DAA, but eventually he calmed down and she assisted him into his chair. DA B documented she did not feel TLA should handle Client #1's behaviors because TLA was too aggressive with Client #1.

Review of a written statement completed by Registered Nurse (RN) A noted she had heard Client #1 on the phone telling his dad a staff had stepped on his hand and it hurt. RN A

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W 153	Continued From page 6 documented she assessed Client #1 for injuries and asked him if anything hurt. RN A noted initially Client #1 reported he felt fine and then stated his hand hurt. RN A documented there was a reddened area on the second knuckle with six pinpoint open areas on the top of Client #1's right hand. RN A continued to note she asked Client #1 what had happened and Client #1 said "His foot on my hand. He stepped on my hand." When asked who stepped on his hand, Client #1 stated, "(TL A) stepped on my hand." Additional record review revealed Client #1 was 52 years old and had resided at the facility since 2/1/2019. Client #1 was diagnosed with, but not limited to moderate intellectual disabilities, Down Syndrome, Celiac Disease, other recurrent Depressive Disorder, Anxiety Disorder unspecified, spinal instabilities, Obsessive-Compulsive Disorder unspecified, Alzheimer's Disease with early onset, unsteadiness on feet, degenerative disease of the nervous system unspecified, and generalized muscle weakness. Review of facility policies revealed the "Mandatory Reporting of Dependent Adult Abuse, Crimes, and Other Notifications" policy, last revised 8/24/2016. The policy instructed employees were to immediately notify the person in charge, or the person's designated agent, of any allegations of abuse. Additional review of policies revealed the "Abuse Prevention, Training, and Investigations", last revised 8/24/2016. The policy instructed "Employees are required to report incidents - anything unusual or unexpected - at the time of the occurrence, to their supervisor or person in	W 153		

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W 153	Continued From page 7 charge of the facility for further investigation, regardless of whether the incident results in obvious or visible injury." The policy continued to instruct, employees were required to report allegations or suspicions of mistreatment, abuse, or other crimes "immediately and without hesitation" directly to the person in charge of the facility at the time. The policy instructed if the person in charge was not the Administrator, the employee was also required to report the allegation to the Administrator within one hour. When interviewed on 7/29/2020 at 12:05 p.m., DA A reported she did not recall the exact day of the incident but remembered what had occurred. DA A said Client #1 was engaging in maladaptive behaviors and they were able to get him into this bedroom. She stated Client #1 grabbed TL A's shirt and pulled them both down to the floor. DA A explained TL A moved back away from Client #1, stood up, kicked Client #1 in the back of the head, walked out of Client #1's bedroom and closed the door. She said TL A was the supervisor working so the following day when she arrived to work she reported the allegation of abuse to the Program Coordinator (PC) and the Behavior Strategist. She explained she did not immediately report the allegation because TL A was the supervisor and was the person who had kicked Client #1. The Surveyor called DA B on 7/29/2020 at 2:14 p.m., 7/30/2020 at 10:12 a.m., and 8/5/2020 at 2:42 p.m and left messages requesting a return phone call. DA B did not return the Surveyor's phone calls. When interviewed on 8/3/2020 at 9:10 a.m., the PC said on 12/8/2019 Client #1 had been	W 153		

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W 153	Continued From page 8 exhibiting inappropriate behaviors and she was called to seek approval to obtain an order for a PRN (as needed) medication. She reported no one reported any allegations when she was called. The PC stated the next day, Client #1 was overheard on the phone telling his father the guy stepped on his hand. She explained the nurse assessed Client #1 and Client #1 had marks consistent with his behavior and/or having his hand stepped on. The PC said when DA A and DA B arrived to work on 12/9/2019, they reported the allegation of abuse to her. The PC confirmed DA A and DA B failed to immediately report the allegation of abuse.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to complete a thorough investigation into all allegations of client mistreatment and/or abuse. This affected 1 of 1 client (Client #1) involved in the investigation of #88494-I. Findings follow: Record review on 7/23/2020 revealed the facility self-reported an allegation of abuse to the Iowa Department of Inspections and Appeals (DIA). The facility reported on 12/8/2019 Client #1 was exhibiting maladaptive behaviors and staff assisted him to his bedroom to calm down. While in his bedroom, Client #1 grabbed Team Lead (TL) A's shirt and began hitting, kicking, and scratching. TL A put his arm up to block Client #1	W 154		

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W 154	Continued From page 9 from head butting him. The behavior continued and both Client #1 and TL A fell to the ground; Client #1 began grabbing TL A's pants and attempted to bite his ankles. It was reported TL A might have stepped on Client #1's hand. The facility failed to include staff also alleged TL A had kicked Client #1 prior to exiting Client #1's bedroom. Continued record review revealed the facility internal investigation, which included the following: a. A written statement completed by Developmental Aide (DA) A. DA A documented Client #1 had been in several behaviors when he came from his bedroom and was attempting to hit her in the hallway. She called for help and TL A came from his office to assist. DA A documented TL A walked up, grabbed Client #1 by one arm and the back of Client #1's neck, and pushed Client #1 inside his bedroom. DA A continued to note Client #1 reached out, grabbed TL A's shirt, and both TL A and Client #1 fell to the ground. TL A again grabbed the back of Client #1's neck while yelling at Client #1 to release his shirt. DA A reported she and DA B attempted to get Client #1 to de-escalate and to release TL A's shirt. DA A documented after TL A was able to get up off the floor, he walked by Client #1 and kicked him on the back, leaving Client #1 on the floor as TL A exited the bedroom. DA A documented as TL A stated he had it and to just leave Client #1, Client #1 reached over, grabbed TL A's pants, and attempted to bite his ankle. DA A noted TL A stepped on Client #1's hand and Client #1 released TL A. b. A written statement completed by DA B. DA B	W 154		

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W 154	Continued From page 10 wrote on 12/8/2019 Client #1 was having a behavior outside of his bedroom and mats were used to keep Client #1 inside the room. DA B documented Client #1 had raised his fist toward TL A and she attempted to intervene but before she could get around the mats, Client #1 fell to the ground and attempted to bite TL A's ankle. DA B documented TL A kicked Client #1's head away. DA B noted she got in front of Client #1, Client #1 threw his shoe at DA A, but eventually he calmed down and she assisted him into his chair. DA B documented she did not feel TL A should handle Client #1's behaviors because TL A was too aggressive with Client #1. c. Client #1's Progress Notes, completed by nursing staff. On 12/8/2019 Registered Nurse (RN) B noted Client #1 had numerous verbal outbursts and three physical outbursts, staff had redirected Client #1, offered food/drink, one-on-one time, time out in his bedroom, he showered and there was no change in behavior. RN B completed a second note after calling the Program Coordinator (PC), Behavior Strategist, Client #1's physician, and pharmacy about obtaining a one-time order for Ativan two milligrams intramuscularly; she noted the medication was given in Client #1's right deltoid without difficulty. On 12/9/2019, RN B noted she had completed an assessment of Client #1 due to an incident on 12/8/2019, which was being investigation. RN B documented she assessed Client #1's head, back, neck, right arm and right hand and noted Client #1 had slight redness to his right hand on the second knuckle and had six pinpoint open areas, possible due to the many behaviors Client #1 had over the past few days. d. The facility summary of the incident noted the	W 154		

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W 154	Continued From page 11 conclusion of the investigation was unknown based on both parties and varied witness statements. The summary included the incident was reported to the Department of Inspections and Appeals (DIA) due to the allegation Client #1's hand was stepped on intentionally. The summary failed to include any information on the allegation TL A had kicked Client #1. When interviewed on 7/29/2020 at 12:05 p.m., DA A reported she did not recall the exact day of the incident but remembered what had occurred. DA A said Client #1 was engaging in maladaptive behaviors and they were able to get him into this bedroom. She stated Client #1 grabbed TL A's shirt and pulled them both down to the floor. DA A explained TL A back away from Client #1, stood up, kicked Client #1 in the back of the head, walked out of Client #1's bedroom and closed the door. She said TL A was the supervisor working so the following day when she arrived to work she reported the allegation of abuse to the Program Coordinator (PC) and the Behavior Strategist. The Surveyor called DA B on 7/29/2020 t 2:14 p.m., 7/30/2020 at 10:12 a.m., and 8/5/2020 at 2:42 p.m. and left a voicemail requesting a callback. DA B did not return the Surveyor's phone call. Review of facility policies revealed "Abuse Prevention, Training, and Investigations" policy, last revised 8/24/2016. The policy instructed every abuse allegation was to be investigated thoroughly. The policy instructed to interview the alleged victim, the alleged perpetrator, and all potential witnesses. Following interviews, each participant was to review and sign each page of the statement, or interview notes, as verification	W 154		

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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 154	Continued From page 12 of accuracy and comprehensiveness. The policy instructed, " Upon completion of the internal investigation, the Administrator should prepare a written summary report containing a description of the allegation; a chronological listing - by date and time - of the steps taken to investigate it; an overview of the findings; identification of the names, titles, and contact information for each person who was interviewed and for each notification and interaction with law enforcement and regulatory oversight agencies." When interviewed on 8/3/2020 at 9:10 a.m., the Program Coordinator explained the injury on Client #1's hand was consistent with either the behaviors Client #1 had been engaging in or from being stepped on. She said when DA A and DA B arrived to work on 12/9/2019 they reported the allegation. She said the nurse assessed Client #1 and no injuries were observed to Client #1's head or back, just to his hand which were consistent with the behaviors he had been exhibiting or from being stepped on. The Administrator explained they had looked into the allegation TL A had kicked Client #1. She stated DA A and DA B were the only two staff who reported TL A had kicked Client #1. She said DA A and DA B both wanted TL A gone because he held them accountable and made them do their job. The Administrator acknowledged the internal investigation failed to include any information regarding the allegation TL A had kicked Client #1.	W 154		

DIA- Plan of Correction

Investigation 88494-I

September 09, 2020

Tag 125- Protection of Client Rights

1. Behavioral strategist has been re-educated on Intensive Care Facility/Intellectually disabled (ICF/ID) protocols in regards to behavior programs and the need for verbal consent immediately and a written signed consent from guardians within 30 days. If a signed written informed consent has not been obtained within 30 days, verbal consent would need to be re-obtained every 30 days thereafter until the written is received. New verbal consents and written consents should be obtained every year thereafter or as needed when changes to programs occur. Dates should be reviewed on a monthly basis by behavior strategist to ensure they are updated and in current standing.

2. Documentation of verbal consent obtained will be documented in Inter-disciplinary (ID) notes at the time of consent. Facility has added that documentation will also be placed in ID notes when informed written consent is received and returned in ID notes. ID notes will be stored in the resident's big chart. The designated behavior strategist will be responsible for obtaining all forms of consents needed and regular updates as needed, or to other designee if behavior strategists are unavailable.

3. Facility has added that two copies of the written consent will be stored on the unit. One will be placed in residents file in Program Coordinator (PC) office and one in large resident chart in the behavior lab.

4. Facility has added that dates will be recorded additionally in Human Right Committee (HRC) minutes when received for PC to monitor on a monthly basis in addition to the tracking sheet for behavior program consents.

5. Program Coordinator will review HRC minutes to ensure data is recorded upon receipt of written consent.

This is effective immediately and everything will be updated by 10/16/2020 to reflect current consents and to monitor what is needed.

Tag 153- Staff Treatment of Clients

1. All staff will continue to take dependent adult and child abuse training every 5 years as mandated by federal guidelines. All staff will also continue to take the course annually on dependent adult abuse provided by ABCM Corporation. Staff will continue to receive education

regarding mandatory abuse reporter training per the policies "Abuse Prevention, Training, and Investigations" and "Mandatory Reporting of Dependent Adult Abuse, Crimes and Other Notifications."

2. Once every 6 months a review of corporate procedure on reporting dependent adult /child abuse will be reviewed in shift meetings. Staff are required to attend shift meetings.

3. Copies of the corporate dependent adult/child abuse procedure will be stored in the ICF/ID policy procedure binder located at the nurses station.

4. Trainings are mandatory are regulated by Human Resources, Managers, Administration, and Corporate.

5. Student Development staff will conduct audits to ensure compliance with dependent child/adult abuse training. Human resources monitors corporate trainings monthly, program supervisor receives reports monthly for staff training and compliancy.

Federal and corporate policies, procedures, and regulations will remain effective for mandatory trainings, binder for ICF/ID unit policy and procedures will be fully completed by 9/25/20.

Tag 154- Staff Treatment of Clients

1. A physical assessment will be completed by nursing staff as soon as practicable after a physical intervention. Additional nursing assessments will be completed after 24 hours, 48 hours, 72 hours and one week

2. Audits will be conducted weekly by the Program Coordinator and nurse managers to ensure assessments are complete and occur within the outlined timeframes.

This procedure has already been implemented and will continue effective immediately 9/16/2020.